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Official Report of Debates (Hansard)

Thursday 23 March 2017



Journal des débats (Hansard)

Jeudi 23 mars 2017

Standing Committee on Finance and Economic Affairs

Medical Assistance in Dying
Statute Law Amendment Act,
2017

Comité permanent des finances et des affaires économiques

Loi de 2017 modifiant des lois
en ce qui concerne l'aide
médicale à mourir

Chair: Peter Z. Milczyn
Clerk: Eric Rennie

Président : Peter Z. Milczyn
Greffier : Eric Rennie

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
FINANCE AND ECONOMIC AFFAIRSCOMITÉ PERMANENT DES FINANCES
ET DES AFFAIRES ÉCONOMIQUES

Thursday 23 March 2017

Jeudi 23 mars 2017

The committee met at 0900 in room 151.

The Chair (Mr. Peter Z. Milczyn): Good morning. Welcome to this meeting of the Standing Committee on Finance and Economic Affairs.

APPOINTMENT OF SUBCOMMITTEE

The Chair (Mr. Peter Z. Milczyn): Members, our first item of business from the agenda is that, given that there is a change in the committee membership as of yesterday, this has left a vacancy on our subcommittee on committee business. We require a motion to replace Ms. Fife as the NDP representative on the subcommittee. Are there any motions on that?

Ms. Ann Hoggarth: I move that Mr. Vanthof replace Ms. Fife on the subcommittee on committee business.

The Chair (Mr. Peter Z. Milczyn): Thank you. Any further discussion? All those in favour? Opposed? That is carried.

SUBCOMMITTEE REPORT

The Chair (Mr. Peter Z. Milczyn): We also have a report from the subcommittee on committee business outlining the process to be followed for the committee. Would somebody like to move a motion adopting or amending that report? Somebody has to read the report into the record.

Ms. Ann Hoggarth: I'll read it, if you want.

M^{me} France Gélinas: I don't care. I can read.

The Chair (Mr. Peter Z. Milczyn): All right. Madame Gélinas.

M^{me} France Gélinas: Your subcommittee on committee business met on Monday, March 20, 2017, to consider the method of proceeding with Bill 84, An Act to amend various Acts with respect to medical assistance in dying, and recommends the following:

(1) That the committee meet at Queen's Park on Thursday, March 23, 2017, and Thursday, March 30, 2017, for the purpose of public hearings.

(2) That the Clerk of the Committee post information regarding public hearings on the Ontario parliamentary channel, the Legislative Assembly website and on CNW newswire service.

(3) That the Clerk of the Committee, with the authorization of the Chair, place an advertisement in a major newspaper for one day in a city in each of the north,

south, east and west regions of the province, and in Toronto, and that the advertisements be placed in both English and French papers where possible.

(4) That the Chair, on behalf of the committee, request the House leaders to authorize the committee to meet from 9 a.m. to 10:15 a.m. and from 3 p.m. to 6 p.m. on Tuesday, April 11, 2017, for the purpose of clause-by-clause consideration of the bill.

(5) That interested people who wish to be considered to appear before the committee on Thursday, March 23, 2017, contact the Clerk of the Committee by 12 noon on Wednesday, March 22, 2017; and that they be scheduled on a first-come, first-served basis.

(6) That the Clerk of the Committee provide the subcommittee members with an electronic list of potential presenters who have requested to appear before the committee by 1 p.m. on Wednesday, March 22, 2017.

(7) That interested people who wish to be considered to appear before the committee on Thursday, March 30, 2017, contact the Clerk of the Committee by 6 p.m. on Tuesday, March 28, 2017.

(8) That if all witnesses cannot be accommodated on Thursday, March 30, 2017, the Clerk of the Committee provide the subcommittee members with an electronic list of all those who have requested to appear before 9 a.m. on Wednesday, March 29, 2017, and that the caucuses provide the Clerk with a prioritized list of those to be scheduled by 10 a.m. that same day.

(9) That the witnesses be offered six minutes for their presentation and nine minutes for questions by committee members, evenly divided on a rotation by caucus.

(10) That the deadline for written submissions be 6 p.m. on the last day of public hearings.

(11) That the research officer provide a fact sheet about the relevant federal legislation to the committee by 12 noon on Wednesday, March 22, 2017, and that it be made available in English and French for witnesses and the public.

(12) That the research officer provide a summary of the oral and written submissions by 9 a.m. on Wednesday, April 5, 2017.

(13) That amendments to Bill 84 be filed with the Clerk of the Committee by 12 noon on Friday, April 7, 2017.

(14) That the Clerk of the Committee, in consultation with the Chair, be authorized to make any arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Peter Z. Milczyn): Thank you, Madame Gélinas. Any discussion? Ms. Hoggarth.

Ms. Ann Hoggarth: Well, it's very minor, but for number (8), where it says "requested to appear," Madame Gélinas said "before 9 a.m."; it says "by 9 a.m." I know that's just technical—

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you.

Madame Gélinas moves the subcommittee report. Is there any discussion?

M^{me} France Gélinas: Just a quick discussion: I beg the indulgence of my fellow members that, depending on how many people wish to attend and the number of slots required, we keep in the back of our minds that if the demand is there, maybe we consider adding another day. Right now, it's not like this, but if the request was there, I would beg the indulgence of the committee that we look at it then.

The Chair (Mr. Peter Z. Milczyn): That's not an amendment, though?

M^{me} France Gélinas: No, it's not. It's just telling my fellow members that I may come with ideas later.

The Chair (Mr. Peter Z. Milczyn): Okay. Thank you.

So, on the subcommittee report, is there any discussion? Madame Gélinas moved it. All those in favour of its adoption? Opposed? That is carried. Thank you.

MEDICAL ASSISTANCE IN DYING STATUTE LAW AMENDMENT ACT, 2017

LOI DE 2017 MODIFIANT DES LOIS EN CE QUI CONCERNE L'AIDE MÉDICALE À MOURIR

Consideration of the following bill:

Bill 84, An Act to amend various Acts with respect to medical assistance in dying / Projet de loi 84, Loi modifiant diverses lois en ce qui concerne l'aide médicale à mourir.

The Chair (Mr. Peter Z. Milczyn): Now we can proceed on to the purpose of this morning's meeting. We're meeting for public hearings on Bill 84, An Act to amend various Acts with respect to medical assistance in dying. Each witness will receive up to six minutes for their presentation, followed by nine minutes of questioning from the committee, which will be three minutes from each caucus. The first round of questioning will begin with the official opposition.

Are there any questions before we begin? No.

COALITION FOR HEALTHCARE AND CONSCIENCE

The Chair (Mr. Peter Z. Milczyn): Our first witness for this morning is the Coalition for HealthCARE and Conscience. If you're here, please come forward. Thank you.

Good morning, sir. As you begin your presentation, if you could please state your name for the official record, and you have six minutes.

Mr. Larry Worthen: Thank you, Mr. Chair. My name is Larry Worthen. I'm representing the Coalition for HealthCARE and Conscience, which is a coalition of 10 different organizations concerned about this issue. The names of the organizations are in your materials. I'm also the executive director of the Christian Medical and Dental Society, which is one of the members of the coalition.

Our concern is that Bill 84 does not, at present, include conscience protection for physicians and other health care professionals. Thousands of doctors in Ontario are currently in a very stressful and impossible situation. If they stay true to their moral convictions, they are currently at risk of being disciplined by their regulatory body because of their inability to participate in medical assistance in dying.

The College of Physicians and Surgeons of Ontario has passed a policy that requires effective referral for medical assistance in dying. The Ministry of Health has a referral telephone line that requires doctors to refer their patients to someone who would assess or perform MAID. Our members cannot possibly do what the college and the government expect us to.

Doctors and nurses know from experience that patients can ask to die as a cry for help. Loneliness, isolation, poverty, disability or mental illness, added to a diagnosis of a serious, life-threatening illness, would lead anyone to question the value of life, yet so many times, for so many patients, the proper care and supports have helped people overcome these challenges to lead a meaningful life. We have seen relationships restored, milestones celebrated and lives lived when, at first, there appeared to be no hope. And we have also seen treatments that, despite all odds, have led to months and even years of prolonged life.

0910

When we are required to participate in the destruction of someone's life, we are being asked to close the book on a patient when there may in fact be more chapters to be written.

We would of course not force a patient to prolong their life against their will, or stand in their way if they wanted to use MAID, but by the same token it is not right that we should be forced to participate in the death of a patient that goes against the very reasons we became doctors and nurses in the first place. Even physicians who are theoretically in favour of assisted suicide are having emotional difficulty following through, as we have read in a recent article in the National Post.

A referral is a recommendation that a patient under our care should be put at risk of being killed. It's a denial of our solemn responsibilities to God and our neighbours, and Catholic, evangelical and Orthodox Jewish theological experts support this principled and moral conviction that a referral for us is morally the same as killing a patient.

Other members of our coalition who do not come from an established faith are concerned because to require them to refer asks them not to adhere to the Hippocratic oath or their personal creed. The standard of medical care, “First, do no harm,” has been in place for millennia.

Now, we are not seeking to turn back the clock about decisions that have been made at the Supreme Court or in Parliament legalizing MAID. We understand that it is legal in the country. Our primary concern is our patients. We want to be there for our patients in their suffering to continue to care for them. If a patient brings up the subject of MAID, we’re prepared to discuss it with our patients, determine the cause of suffering and work with them to find solutions to that.

We understand that some patients will request MAID, and we simply ask that when one of our patients decides to pursue MAID, we not be forced to participate in placing him or her at risk in any way—and “participation” means doing anything that would cause someone to be put at risk.

This policy, unfortunately, has become a litmus test that could be used to effectively exclude certain people and certain beliefs from the medical profession, based solely on their conscience or religious beliefs. CPSO experts have insisted that conscientiously objecting physicians will have to leave family medicine, palliative care and other specialties, and move to a small number of specialties like pathology or cosmetic surgery. This is a view held by Winnipeg ethicist Dr. Arthur Schafer, who, incidentally, was chosen by the government to sit on the provincial-territorial expert advisory committee. He’s gone on record as saying that physicians with conscientious objections should go into sports medicine and stay away from end-of-life issues. And prominent Canadian medical ethicist Dr. Udo Schüklenk, from Queen’s University, has publicly advocated for a morals test to be applied to medical school applicants to screen out those with conscientious objections.

This is deeply distressing for our members and I would submit should be deeply distressing for the Ontario Legislature. It really has made many of us question whether we are welcome to continue to care for patients in Ontario in a health system for which people of faith and conscience have been founding pillars.

We want to reassure you that there is another way. No foreign jurisdiction that has legalized assisted suicide has required doctors or nurses to participate against their will, and there’s no indication that this has caused any crisis in access. Other provinces—specifically Alberta—have come up with innovative options.

In your package you’ll find affidavits from Mary Shariff, who is a worldwide expert on assisted dying protocols throughout the world, and Brendan Leier, who speaks specifically about the Alberta model. In fact, the Supreme Court, in the Carter case, said that nothing in their decision would compel physicians to participate in assisted dying. The court said that “a physician’s decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief.” We simply ask

that those rights that are guaranteed to us under the Constitution be respected.

We understand that the Ministry of Health and Long-Term Care has proposed a care coordination service, which would allow members of the public direct access to an assessment to MAID through a multidisciplinary service that would provide a range of options in end-of-life care—

The Chair (Mr. Peter Z. Milczyn): Mr. Worthen, I have to stop you there. That’s been six minutes.

Mr. Larry Worthen: Thank you.

The Chair (Mr. Peter Z. Milczyn): We’ll move to questions. Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you. Did you want to finish your statement?

Mr. Larry Worthen: Just briefly to thank the committee for this opportunity, Mr. Yurek. Thank you.

Mr. Jeff Yurek: Thanks for being here. One of the arguments I hear about giving conscience rights protection to medical professionals is that they in fact will be abandoning their patients. Is that at all true?

Mr. Larry Worthen: No, actually, it’s exactly the opposite. In your package that I provided you with, on page 2, we have our plan that demonstrates how we could allow for conscientious objection while maintaining the existing physician-patient relationship. If there was a care coordination service in place, and if a patient was able to access that assessment through that care coordination service, then our doctors would be able to continue to provide all aspects of care to that patient. We would not have to negatively impact that physician-patient relationship. Nothing could be further from the truth.

Mr. Jeff Yurek: My second question is, in speaking with the CPS—they’re of the belief that this effective referral doesn’t make you part of the process, in the eyes of medical professionals. Do you have a comment towards that?

Mr. Larry Worthen: The problem with that is that they don’t understand our conscience or religious beliefs. There is a problem when a regulator feels that they can impose their views on us. Their idea is that this is not a problem for them, so therefore it shouldn’t be a problem for us. But the legal test for this has got to be what we believe.

It’s not just a few isolated doctors. It’s established religious groups, like the Orthodox Jewish community, the Roman Catholic community, the evangelical community, many Muslims, and people who are not part of an organized religion.

I think it’s wrong for the college to say, “Look, it’s not a problem for us. We don’t see why it’s a problem for you.” It just shows their insensitivity to these conscience issues.

Mr. Jeff Yurek: Do I have a few more seconds?

The Chair (Mr. Peter Z. Milczyn): One minute.

Mr. Jeff Yurek: One minute? Great.

So if conscience protection was granted and the government incorporated this care coordination system,

patient access to MAID would not be affected? It would still be accessible, as it is in any other jurisdiction?

Mr. Larry Worthen: Absolutely, and, I would venture to say, more accessible than in the current system.

Mr. Jeff Yurek: Okay. How so?

Mr. Larry Worthen: The current system requires that the doctor contact a number, get the name of a doctor who will do—I've spoken to one physician who actually does medical aid in dying. He said that in one case, the patient had been euthanized, and he got a referral from the referral service two days later. So the current referral service is creating a bottleneck, and it's also inefficient, because it's providing a resource that might not be the best resource for the patient.

This allows the patients to access directly. It should not require referral from the doctor. Then the patients can be assessed not by a physician but by a social worker or someone else who can determine exactly what their needs are, to provide the medical help when it's necessary.

The Chair (Mr. Peter Z. Milczyn): Thank you. Madame Gélinas, for three minutes.

M^{me} France Gélinas: It's always a pleasure to see you. I wanted you to put on the record: Were you consulted before the government brought this bill forward?

Mr. Larry Worthen: No, we were not.

M^{me} France Gélinas: Okay. If you had had an opportunity to be consulted and had an opportunity to find solutions, do you figure we would be at the point we are today?

Mr. Larry Worthen: Not at all, no. I believe that if we were able to sit down and work through this in a respectful way, so that our conscience concerns were understood and listened to, I think that there are many, many ways that this could be resolved.

M^{me} France Gélinas: We've known about this for a long time. I don't understand why we were not more proactive in getting people to have a safe place to have this conversation. Now we've ended up with this very polarized discourse that does our community no good.

Quebec went at it very differently. They went out, they consulted and they found middle ground where you can respect people's conscience and you can maintain access. We have none of that in Ontario.

The proposals that you have forwarded to create care coordination—have you had an opportunity to talk to the Ministry of Health? Are they open to this? Do you know what it would look like?

Mr. Larry Worthen: There was a meeting that was held with ourselves and the Ministry of Health in which the idea of a care coordination service was raised. I have been told there would be a consultation; I haven't yet been invited. But I think the problem was that when we were told there was a care coordination service, we were also told that we were going to be required to refer. That, to me, doesn't make any sense, because the whole idea of a care coordination service is that patients can access it directly. Why also then require an effective referral?

0920

Part of my frustration with this, I think, is that the college, in my view, is the wrong place for this to be decided. It really requires, in my opinion, the Ontario provincial Parliament, because they are the ones who can look at all the various sides of this issue and come up with something that is going to allow both conscience rights and access to occur. The college doesn't have the mechanisms to be able to create a care coordination service.

What's required is, we need the Legislature, the college and people with conscience concerns to work together to find a solution that can be a win-win for everybody. I believe a solution is there. Unfortunately, we've been required to use the courts to challenge the college, which in itself is inefficient, not very effective and only builds walls as opposed to tearing them down.

The Chair (Mr. Peter Z. Milczyn): Thank you. Our next round of questions is from the government side. Mr. Fraser, three minutes.

Mr. John Fraser: Thank you very much for being here. It's good to see you again.

Mr. Larry Worthen: It's good to see you too.

Mr. John Fraser: It's been about a year or so. I wanted to just start by telling you a little bit of a story—I may have told you this already, but just for the sake of the committee. My mother is a nurse. She's a very devout Catholic of faith. I said to my mum, "Mum? Do you think that you could do this? Do you think you could participate in assisted dying?"

She said, "No, I don't believe that I could, because this is what I believe." In the next breath she says to me, "But there are extreme circumstances." What she was saying to me is, "You're asking me a question to which I have no proximity. I'm giving you the answer that I believe the answer is right now."

I think one of the challenges that we have here with assisted dying throughout this country is that it's something that we, individually—many of us, most of us—have no proximity to, and as a society, we've had no proximity to. This is nine months old. I think that conscience rights are critical. They're part of our charter.

I really believe as well that the rights of duty that every college creates for practitioners are important too. We have to figure out a way to balance those two rights, to make sure that people get access as well as that peoples' rights of conscience protected under the charter are there.

There's a commitment to establish the care coordination service. I think that that's critical not just because it may create some space—but it also creates space for patients, provides better access and provides, perhaps for them, maybe anonymity or a comfortable space for them to be able to talk about something that they may not be able to talk to anyone else about, whether it's their nurse practitioner, their doctor, their dentist. There is a commitment to get that done.

I do also want to just add that that case that you talked about earlier in terms of the patient being euthanized two days later—it was a multiple-access case where the

patient was looking through multiple avenues to try and get that service. It wasn't that the service wasn't working. It's just that you had three or four points going at the same time.

I think that the ministry has done very well in terms of coordinating that service. There is a lot of work to do. There are some real challenges in rural areas for access for people. I know from the care coordination service that you've had an opportunity to speak with the ADM and some colleagues from the Ministry of Health. I want to assure you that that commitment is there.

I do want to ask you a question in reference to my colleague across the way who was describing the consultation process of Quebec. I believe our consultation process is really robust in terms of, as we were coming forward with this bill, online and in-person—

The Chair (Mr. Peter Z. Milczyn): Thank you. That was three minutes, Mr. Fraser.

Mr. Worthen, thank you very much for your presentation today. If you wish to make any further written submissions, you have until 6 p.m. on Thursday, March 30, to submit them through the Clerk.

Mr. Larry Worthen: Thank you very much.

DR. ALTHEA BURRELL

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Althea Burrell.

Dr. Althea Burrell: Hello.

The Chair (Mr. Peter Z. Milczyn): Good morning, Doctor. You have six minutes for your presentation, and if you could please state your name for the official record as your begin.

Dr. Althea Burrell: I'm Dr. Althea Burrell. Good morning, everyone. I have no experience presenting anything before a committee. This is about my 10th revision, so if I speak too fast, please wave your hands.

I'd like to thank you for giving me the opportunity to speak to you today on this very important issue. I am here today to ask you—to implore you, really—to amend this bill to include conscience protections for health care workers such as myself.

I am a doctor. I am a subspecialist in pulmonary medicine. This is the care of people with serious lung diseases, nearly all of which are incurable. I work with my patients on a daily basis to relieve their symptoms, improve their quality of life and prevent their deterioration.

If I expect a patient may die from their lung disease, I try to prepare them for this and I try to prepare their family for this. I also make a point of meeting with families after a patient passes—particularly if they die in hospital or unexpectedly—to allow them to ask questions and help them to achieve closure.

It is with my own practical experiences in mind that I address the committee today. I will speak to three reasons why an amendment protecting conscience rights should be added to Bill 84.

First, it is the responsibility of the Ontario Legislature to address the issue of conscience rights, as they pertain to medical assistance in dying. All Canadians, including health care workers, have the fundamental rights to freedom of conscience and religion, as per section 2(a) of the Canadian Charter of Rights and Freedoms. It is the responsibility of this provincial government to regulate health care in such a way as to respect these rights, and the Supreme Court of Canada, in the Carter decision, specifically required that it do so in the context of MAID.

Therefore, this duty—that of protecting the charter rights of physicians—falls to this Legislature. It cannot be delegated to the College of Physicians and Surgeons of Ontario, the mandate of which is to protect the public interest, not specifically to protect the rights of physicians.

Secondly, an amendment upholding conscience rights is needed because the current regulatory requirements violate the consciences of doctors like myself. Although I am not forced to actually provide euthanasia or physician-assisted suicide, I am forced to refer my patients to another doctor, who is both willing and available to provide MAID.

This means that I am—quite apart from my intentions—nevertheless instrumental in bringing about the death of my patient, and therefore I bear moral responsibility for that outcome. “Effective referral” is therefore not a reasonable or adequate compromise to the ethical problem of medical assistance in dying. Forcing me to refer patients for euthanasia does not meaningfully or adequately address my conscientious objection to euthanasia.

However, providing a means for patients to access MAID directly, without a referral, would resolve this problem. I would be able to advise patients that they could access this service without a referral, and I could continue then to care for them in all other aspects of their care, which is very important because these are complex patients.

As well, Ontario is the only jurisdiction in the world that requires this effective referral of its physicians. If I were the government, that would concern me, because we are really an unfortunate outlier in this regard.

Finally, an amendment to Bill 84 that provides conscience protections for health care workers is also beneficial to patients, because it enhances patient choice. This is very important. The legalization of MAID has forever changed the relationship between patients and their doctors. Over the past several weeks, I have heard from many people who want to receive their end-of-life care from doctors and nurses who do not refer for MAID or provide MAID as part of their medical practice. These people also want to be cared for in hospitals and hospices where MAID is not performed. These people want access to a care team that shares their view that life is to be affirmed until natural death.

As a patient, I understand this perspective. I would also want my care team to share my views on the end of life, especially when things become difficult for me. My personal experience of pain and suffering is that it

becomes much harder to bear suffering when one has the possibility of a quick exit.

The only way to provide patients with access to a care team that will affirm their end-of-life values is to allow doctors, nurses and other health care providers to practise medicine according to their consciences. They cannot be forced to participate in medical assistance in dying against their will.

0930

At this time, I would like to thank the committee for hearing me today. I hope that I have shown you that conscience protections are important for physicians and for patients and that it is the duty of this Legislature to act on this very important issue. Thank you for your time.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor. Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Thank you so much for your presentation, and for your first time at Queen's Park you did very well.

Dr. Althea Burrell: Thanks.

M^{me} France Gélinas: I know you were in the room when I asked a question of the first presenter. My first question to you will be the same. We have known about the Carter decision in the Supreme Court for years now. In all that time, have you ever been consulted by the provincial government?

Dr. Althea Burrell: No.

M^{me} France Gélinas: Do you think you should have?

Dr. Althea Burrell: Yes.

M^{me} France Gélinas: And why do you think that?

Dr. Althea Burrell: It's interesting that you raise this. When the college brought their policy on effective referral forward, it was before the Supreme Court handed down their decision—I think it was February 2015. When they did this, they were having draft consultations. I wrote to them in a bit of a panic, and I said, "You know, you realize this policy is going to require physicians to refer people for euthanasia when the Supreme Court hands down its decision," because that was what I expected. I received no response from that.

A number of other people also wrote in to express their concerns, and they also received no response; members of the public, similarly. This policy was then brought forward. The Supreme Court then legalized euthanasia, at which point various consultations took place. I went to them.

Bill C-14 did not have any conscience protections, therefore I'm bringing this to Ontario because it's really the last resort that I have for this very important topic, and I think that it is incumbent on the Legislature to address the needs of the public. I'm a member of the public, and I think the conscience protections are required for myself and also to protect my patients.

M^{me} France Gélinas: I think the answer you just gave us, we hear this throughout. There is a pent-up demand among Ontarians and among health care professionals to have a safe place to have those dialogues so that we can find a middle ground that will protect conscience, and make sure that the access is there, given that it is the law.

You were not the only one who was not consulted. None of us was. We never created this safe place, and now we've come out with a bill, which is in second reading, which is very close to the last step.

Other provinces went at it very differently. Quebec has been consulting for the last five years. They put a report out. They let everybody—so they were able to find middle ground. The same thing with Alberta; they were able to find middle ground because they provided a safe place for a conversation. Ontario did not, and now we're stuck with good people like you having to come here at the very last step of the legislative process for something that should have been a whole lot more robust before it came to us.

The Chair (Mr. Peter Z. Milczyn): Thank you, Madame Gélinas.

Questions from the government side now: Mr. Fraser, three minutes.

Mr. John Fraser: Thank you very much, Dr. Burrell, for being here and for the work that you do.

I do have to address something that the member opposite had to say. I believe that our consultation process was very thorough. I know she's referencing Quebec. From the Quebec experience, are you saying that you will be satisfied if we have the same rules as they have in Quebec?

Dr. Althea Burrell: So I'm not an expert on the Quebec process, but I do not think that they provide robust conscience protections for their health care workers in Quebec—and I'm not an expert on that process.

What I am asking is that you protect my conscience rights in Ontario in this way, and I think an amendment to this bill is a good way forward. I also think that having patients able to directly access the service is appropriate, in fact.

Mr. John Fraser: I agree with you on the direct access. I don't believe either the rights of conscience or effective referral belong in this bill.

I want to remind the member opposite as well that this is a very technical bill that protects people on issues like insurance—

Dr. Althea Burrell: So can I ask the member—I'm sorry. I understand the bill—

Mr. John Fraser: Can I just finish my question?

The Chair (Mr. Peter Z. Milczyn): Dr. Burrell, you don't ask the questions, unfortunately.

Dr. Althea Burrell: Oh, sorry.

Mr. John Fraser: You can ask me one later. I'll be glad to talk to you.

Protection—how much time do I have?

The Chair (Mr. Peter Z. Milczyn): One and a half minutes.

Mr. John Fraser: WSIB protects records collection—

Dr. Althea Burrell: I've read the bill.

Mr. John Fraser:—things in the Coroners Act. Okay? It's a very technical bill.

I agree: We need to balance those two rights and create pathways. I think that's the only way forward. I don't think you can do that inside this bill. That's what I

believe. I know that we need to do that—and I'll ask you—because this is a thing that will, over time, as those pathways develop, evolve and change. I'd be glad to have another conversation with you about this afterwards.

Dr. Althea Burrell: In the meantime, if I'm forced to refer my patients, I'm subject to potential loss of my licence to practise medicine while those pathways are being worked out over time. Because of the college's effective referral policy, I can be disciplined for not referring patients to things that will result in their death, and I can't do that. So it's not really acceptable to say that we're going to work out, over time, these issues.

I do think that conscience protections are the responsibility of the Legislature. If it's not in this bill, I would like to ask the member where that should be, because obviously, it's not going to be at the college level.

Mr. John Fraser: It's protected under the charter—and both of those rights are charter rights that we're talking about.

Every college that I've looked at, when I do a cross-jurisdictional scan, has stuff on duty of care that has duty of referral and duty of transfer to care. Everybody has it. It's critical.

Dr. Althea Burrell: I agree with you.

Mr. John Fraser: I can understand the moral dilemma that exists there—

The Chair (Mr. Peter Z. Milczyn): Thank you, Mr. Fraser.

We'll switch over to the official opposition. Mr. Yurek, three minutes.

Mr. Jeff Yurek: Thank you for coming out to speak today. The member opposite, I think, is wrong when he says that this isn't the place to discuss conscience rights, in this bill. This bill is ensuring the rights of others are protected, family members and such, to attain their life insurance or ensure their workers' compensation. It's ensuring the right to privacy to those patients who undergo medically assisted dying, and to the health care providers who are providing it. I think this is a perfect opportunity, since it was obviously missed during the creation of this legislation, to have this topic of discussion.

It's unfortunate that the member opposite wants to discuss this off-line and not on Hansard, having the discussion in full amongst all the members of the Legislature instead of having these private consultations. It's unfortunate that that's how he wants to deal with the situation.

My question to you is with regard to the moral screenings that were proposed by the last witness. Are you concerned that this might actually take place going forward, that people will be screened out based on their conscience beliefs and thoughts?

Dr. Althea Burrell: Yes. That's been stated publicly by people. These people have said, "There are enough people who want to be doctors in the world. We don't need you. We don't need people who object to referring patients to die. We have lots of people who have no problems with this and we can just admit them into the practice of medicine."

The problem with that is that the practice of medicine is inherently moral because it operates on the human person. Anything that I do "for" the patient I do "to" the patient. I can't separate my moral integrity from the care of the patient. If I refer them for a test, like an angiogram, and they come to harm, such as a recognized complication of that angiogram, which is a stroke—if they are coming to harm because I referred them for a test and I recommended it, then I'm responsible for that harm. I bear moral responsibility for that.

Mr. Jeff Yurek: My question is, if you were protected in your conscience rights, would (1) your patients suffer at all due to the fact that you would not provide medical assistance in dying, and (2) would they still have access, as much as they do today, to the service?

Dr. Althea Burrell: One very distressing thing about this is that it has been suggested that if I can't provide this care service to a patient, they should be able to go to somebody and transfer their care to somebody who will. I want to continue to provide care for my patients. I don't want to abandon my patients. When they ask for MAID, that's a cry for help. I want to be able to explore that with them and continue to look after them.

The only thing I ask is that when it comes to actually facilitating arranging their death, I do not have to be involved in that decision. I would have a very clear conversation with the patient, explain this to them, explain what their options are and how they can access those options, and then I would like to tell them that I would like to continue to care for them as long as possible, even through that MAID process. I have no intention of abandoning my patients—quite the opposite—and I really don't believe that people will have trouble accessing MAID if there is a direct access pathway.

They're able to come to my office and talk to me about this. I don't see why they can't make a phone call or go on a website.

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The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Burrell, for coming in today. If you wish to make a written submission to the committee, you have until 6 p.m. on Thursday, March 30, to do so.

Dr. Althea Burrell: Okay. Sorry if I breached protocol.

The Chair (Mr. Peter Z. Milczyn): No, you did not. You did great.

Dr. Althea Burrell: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Peter Z. Milczyn): Our next witnesses are with the Registered Nurses' Association of Ontario.

Good morning. You have six minutes for your presentation. If you could please state your names for the official record as you begin.

Dr. Doris Grinspun: Thank you very much, Mr. Chair. Good morning to all. My name is Doris Grinspun.

I'm a registered nurse and the CEO of the Registered Nurses' Association of Ontario, or, as it is most known, the RNAO. With me today is Cheryl LaRonde-Ogilvie, a registered nurse and nursing policy analyst with RNAO.

As the professional association representing registered nurses, nurse practitioners and nursing students in Ontario, we thank you for the opportunity to provide advice regarding Bill 84. We are actually most distressed that other groups claim to represent RNAO—to represent nurses—right in front of us. We represent the nurses of this province.

Nurses have a unique therapeutic relationship with individuals and their families, which positions us well to ensure continuity of care that is responsive to the needs and wishes of our patients. Because of this, we are often the eyes and ears for patients and for the health system, and are likely to play a key role in assisting patients in their end-of-life journey.

RNs and NPs are also leaders in the design and delivery of palliative and end-of-life care, and their full utilization can strengthen access to quality services for Ontarians. However, access to palliative care continues to be a challenge across the province. While NPs are authorized to prescribe medications for a client for self-administration, in Ontario, NPs are still not authorized to prescribe controlled substances, despite federal regulations being amended in 2012.

The College of Nurses of Ontario and the provincial government are now moving to remedy this gap with the regulatory and bylaw changes. Until that happens, this needless limitation of access to end-of-life care, including medical assistance in dying, will continue.

Although the Criminal Code does not permit RNs to administer the medications for MAID, RNs play a significant role, providing nursing care and aiding an NP or physician to provide a person with medical assistance in dying in accordance with the law.

Our first recommendation, therefore, is asking for RNs to be included in the language of the bill, to protect their participation in MAID, by amending all sections of the various acts, including sections 2(1) and 13.8(1)(2) of the Excellent Care for All Act, 2010.

Our second recommendation is to proceed with giving nurse practitioners the authority to prescribe all controlled substances in accordance with federal regulations, to ensure access to MAID across the province. Let me tell you, we are the only jurisdiction that still is not moving with that.

Medical assistance in dying is a very sensitive topic, as we have just heard. The debate had been sharpened by health professionals taking sides in favour of or against MAID. For RNAO, MAID is no longer a topic of debate. MAID is now law and part of our publicly funded health system.

Thus, while RNAO respects the right of health professionals and institutions not to be forced into providing assisted death services, we are of the strong view that in cases of conflict of belief or conscientious objection, there must be a duty to refer that applies to individual

physicians and/or nurse practitioners as well as to health organizations.

Thus, our last recommendation, and likely the most important for this committee, is that a section be added in this bill to include the duty to refer by physicians and nurse practitioners who have a conscientious objection.

In conclusion, RNAO is pleased to provide input to the Standing Committee on Finance and Economic Affairs regarding amendments to Bill 84. We believe the recommendations specified in our written submission, which you have, and our presentation today will strengthen this bill, clarify the bill and advance health services that give Ontarians equitable and timely access to medical assistance in dying while protecting health providers from litigation.

Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Grinspun. This round will begin with the government side.

Mr. Fraser, you have three minutes.

Mr. John Fraser: It's good to see you again. Thank you for being here. Thank you for your presentation and for your suggested amendments. You were probably here earlier, so I'm not going to recount the things. I only have three minutes.

I don't believe that either two of those things—conscience rights or duty to refer—belong inside this bill. It's a bill that's very technical in nature. I do believe we have to balance those rights. I don't think you can do that inside the bill effectively.

I do want to ask you about the care coordination service. I think it's a critical piece for access, which is a concern that you raised. Have you given any thought to that?

Dr. Doris Grinspun: Yes, we have. We believe it's insufficient. We believe, John, that we must, inside this bill, balance conscientious objections of professionals with the rights of patients, not of health professionals—and that's called "duty to refer." Like any other legal services, no doctor, no nurse will say, "I don't want to do dialysis; therefore I am not referring to dialysis." You would refer if you cannot, if you don't know how or if you don't want to do that. This is no different. This is a legal service. We have a duty to refer.

Mr. John Fraser: I understood that very clearly from your presentation, and we've had some—

Dr. Doris Grinspun: The previous colleagues just pointed out why this needs to be actually dealt with in this bill.

Mr. John Fraser: We've had this conversation before.

Dr. Doris Grinspun: Yes, we have.

Mr. John Fraser: I believe that there has to be a patient-facing entry point that can provide people with some anonymity or an ability to talk to somebody. You may be in a place where you don't want to talk to your physician, your dentist or your nurse about what you're thinking about. You may not want your family to know. I think it's a critical piece that will aid in access for patients. To me, that's the most important reason to get that in there. There are provisions in the bill around

protection of privacy and information, which I think are critical—and you would agree—for patients.

How much time?

The Chair (Mr. Peter Z. Milczyn): Thirty seconds.

Mr. John Fraser: Would you or would you not agree that that's an important thing to do?

Dr. Doris Grinspun: It could be important but insufficient, John. We have discussed that. A duty to refer—it's not instead of a duty to refer, like any other legal service that we have in this province.

Mr. John Fraser: I just want to add to my colleague across the way who suggested somehow that I wanted to discuss things outside of Hansard—Jeff, from the official opposition: I think that was really unfair.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser, we're trying to deal with the witnesses now. If you have a point of order, you can raise that. But I don't think that's a point of order.

Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: John, we can talk about that anytime. We don't need to chew up committee time with this.

Thanks, Doris, for being here today. Your first two recommendations I want to touch upon—including RNs into the language of the bill. How did that get missed in the drafting of the legislation? I'm sure you were part of the process.

Dr. Doris Grinspun: The bill currently says, "physicians, nurse practitioners and other health professionals." So I guess we're included in "other." If you think about RNs, likely—if you think that they will be with the physician or they will be with the NP, they're the ones who will be there most of the time, taking care of patients. It's out of respect to RNs that that needs to be outlined specifically.

Mr. Jeff Yurek: You'd think with your expanding scope that we hear is coming that it would be a thing of respect to include the RNs—

Dr. Doris Grinspun: Absolutely.

Mr. Jeff Yurek: On the second recommendation with regard to nurse practitioners, the authority to prescribe: You said it's since 2012 we've been waiting for this to occur?

Dr. Doris Grinspun: We hear it's coming sometime in March, but until we see it signed in the paper and happening, we will continue to push that agenda. It's critical. It's also critical for pain management. It's critical for palliative care, and it is critical for assistance in dying.

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Mr. Jeff Yurek: It's a barrier to access not only to medical assistance in dying but, as you said, other forms of treatment, considering we're creating more nurse practitioner-led clinics around the province and they're expanding their scope and role.

Dr. Doris Grinspun: Yes.

Mr. Jeff Yurek: So is there anything else, other than the three recommendations that you've put forward, that you think we need to have a discussion about?

Dr. Doris Grinspun: Those three recommendations are critical. They're critical for the reasons that we

outlined in the submission. Also, just for the discussion up to this moment today, it proves that it's critical to have inside the law both the conscientious objection and also the duty to refer—both.

Mr. Jeff Yurek: But this legislation is the place to have this discussion—

Dr. Doris Grinspun: I would suggest yes.

Mr. Jeff Yurek: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas, three minutes.

M^{me} France Gélinas: I'll start with the same question. You were there. Did your members have an opportunity to get engaged into discussion that led to the tabling of this bill?

Dr. Doris Grinspun: Yes. Let me start with this: Let's not play politics with this. No individual nurse will be approached, nor should every individual nurse in the province be approached. Nurses—RNs, NPs and, for that matter, nursing students—were heavily involved from the federal legislation, from the court challenge, to absolutely this time, including in looking at the guidelines for Ontario. So, yes, as an association that represents RNs, NPs and nursing students, we have been very much involved.

M^{me} France Gélinas: So how do we explain that nurses are not in the bill?

Dr. Doris Grinspun: Nurse practitioners are, and they are nurses. The same answer that was given to Jeff is given to you, France, which is: likely because they included us under "other." For us, that's insufficient, given the tremendous role that RNs play in the system. So I hope that you, too, and the government will help to remedy that.

M^{me} France Gélinas: I agree with you that as long I don't see it in writing, I won't believe that our NPs will finally be able to prescribe narcotics. So we will keep pushing.

Coming back to effective referral: It's not in the bill. What do you fear by not having it in the bill?

Dr. Doris Grinspun: Well, the same types of discussions that we heard in the previous two presentations. To me, as a health professional, as an association—and I know there are a couple of nurses presenting from the same group. It is unconscionable that any health professional will take the law into their hands. We all have beliefs—whether it's religious, whether it's moral, whether it's other types of beliefs. This is about patients and the public in Ontario. This is about a legal service that is available now to them. This is their choice, not my individual choice. I may oppose providing a service, as I may oppose providing another service—because I'm incompetent to provide dialysis, for example, but I have a duty to refer.

This is the position of the association. And let me tell you, we represent 41,000 RNs and NPs, nurse practitioners. Perhaps there is 2% not outside; all the rest is totally outside. In fact, RNAO was the first organization to put at their AGM four years ago a motion to the members to

have a discussion including medical assistance in dying. It passed by 93%.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Grinspun. That's all our time for today. If you'd like to submit something further in writing, you have until 6 p.m. on Thursday, March 30, to do so.

Dr. Doris Grinspun: Thank you so much.

DR. NORA POPE

The Chair (Mr. Peter Z. Milczyn): Our next witness is Nora Pope. Good morning. You have six minutes for your presentation, and if you could please state your name for the official record as you begin.

Dr. Nora Pope: My name is Nora Pope. I'm a board-certified naturopathic doctor practising in Toronto since 2002. Thank you for the opportunity to present to your standing committee on the topic of Bill 84, An Act to amend various Acts with respect to medical assistance in dying.

I'm going to ask everyone in this room to pretend that we're speaking as atheists here. This is a secular concept; it's not a religious concept. I feel that one of the obstacles to protecting conscience rights is perhaps the perception that religion is encroaching on the matters of state. What I view today—these concepts of conscience rights are secular. They're from the French Enlightenment. Voltaire voiced them centuries ago, so I believe these are secular, public-sphere concepts, not religious concepts.

I believe conscientious objection is the bedrock of civilization. Quakers conscientiously object to war, but war still happens. It doesn't hinder war. So I want my rights of freedom of expression and freedom of thought to be protected, and they won't be if I'm forced to refer one of my patients for MAID. But I think the law is resilient enough and creative enough to protect my rights and protect access for my patients who do want MAID, and I will support them in the process. I will not hinder them, but I don't want to be actively involved in the referral, because I think this is an accessory to killing, and I don't believe in killing.

Number two is that I'm an empirical practitioner. I believe what I see. Patients have benefited from end-of-life care and a natural death, in my view. Palliative care blends seamlessly with naturopathic medicine, and the guiding principles of naturopathic medicine are inherently non-invasive. I treat with the whole person in mind. I try and get to the root cause. I treat like a detective.

So pain, which is a big motivator for wanting MAID, can be alleviated in all kinds of ways. Insomnia can increase pain, so by addressing insomnia, you can reduce the pain and you can create a patient who's far more lucid in really wanting to know whether or not they want to end their life. Emotional unfinished business can increase pain, like guilt, contrition. Regret can increase pain. Social isolation can increase pain. Depression can be linked to a progesterone deficiency. So if these aren't uncovered and dealt with professionally and thoroughly, the patient is far too vulnerable and may be pushed into

wanting MAID without having all their root causes addressed.

In my practice, I treat all kinds of people with ALS, anxiety, depression, and I've seen that medicine can be very curative in removing obstacles to pain and suffering naturally. These patients can have a natural death, which I think is dignified, because it's done in peace, not in haste, not in panic, not in fear.

I really feel for vulnerable patients who may be intimidated by doctors. Doctors are human. What if they're impatient? What if they want to get on with this and just say, "Okay, let's hurry up and finish this process"? Some patients may feel they're under duress. When I'm ready to die, hopefully in my eighties or nineties, I want to be in a hospital that doesn't promote MAID. I want to be in a hospital that respects natural death, and I feel very strongly about this.

Also, doctors are human. I think when a doctor sees a patient in a lot of suffering, they feel helpless and they want a quick solution. I submit that when I hang in there with my patients, when I see them feeling helpless and suffering, I'm there with them. If they want MAID, I will support them.

Most of all, patients can change their minds about wanting suicide and not wanting to live. I refer in my written notes to a documentary called *The Bridge*. This is based on the Golden Gate Bridge and people jumping off the bridge. The film crew filmed it for a whole year and witnessed many, many suicides, but two survivors were interviewed in the film. In midair they changed their mind: "What have I done? I do want to live." So suicide is very, very tenuous at times. It's also very romantic and it's very contagious. So I don't feel we should be expediting this, and I don't feel we should be forcing doctors to refer to a process where a patient may have this expedited. I don't feel it protects my human rights of conscience. All the same, if my patients are lucid and want to choose it, I will support them.

My belief is that killing is immoral. I don't want to be an accessory to killing by being forced to refer patients to MAID.

The Liberal government, and many governments in Canada, are centrist in their view. They represent a broad base. By respecting my human rights of freedom of thought, freedom of conscience, and by ensuring access to MAID, this government broadens its base to protect minority views.

I thank you for your time.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Pope. We'll begin this round with Mr. Yurek for three minutes.

Mr. Jeff Yurek: Thank you for coming in and for your words spoken today and the printout that followed. It was very enlightening.

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It was interesting that you brought up another way to view conscience rights on the secular side. It takes away from the religious side that mainly takes hold of this debate—the fact that conscientious objection with regard

to being drafted into a war in the States wasn't protected and many fled to Canada and such.

Does your college have a view at all on effective referral or not?

Dr. Nora Pope: No. I speak as an individual.

Mr. Jeff Yurek: But has your college come out at all with a position?

Dr. Nora Pope: No.

Mr. Jeff Yurek: No, they haven't yet. Okay. That's interesting.

Do you know at all if your association and/or college was communicated with in the drafting of this legislation?

Dr. Nora Pope: I do not.

Mr. Jeff Yurek: You don't know. Okay.

I brought this up with the last doctor who was up with regard to the potential of moral screening being instituted if conscience is not protected. Even having this debate is a cause for concern. Is it a concern of yours?

Dr. Nora Pope: Tremendous, because it will distort the fabric of society in favour of MAID. We are a pluralistic society and, again, I feel that too much press has been given to, "Oh, people with religious views shouldn't be in health care." I think that's bigoted. I have secular views about why I don't believe in killing. I don't believe in killing. That doesn't get much press, but many, many atheists are not in favour of killing.

Mr. Jeff Yurek: So it's a broader discussion than just focusing on the religious aspect of conscience rights.

Dr. Nora Pope: Absolutely. It's the bedrock of civilization, freedom of conscience. First, for you to live out your life you have to "think, therefore I am." Your thoughts must be protected because how you live out your life is based on what you believe.

Mr. Jeff Yurek: And do you feel that this legislation in front of us is the place to have this discussion and make the necessary protections?

Dr. Nora Pope: I do, because it's coercive to force a physician to refer to MAID. It's coercive if they don't believe in killing.

I'm proud of my profession. Naturopathic medicine can alleviate a lot of suffering, and palliative care is very, very important.

We labour into this world and we labour out of this world. Why do we fear labour? I think people want MAID because they're feeling fearful, vulnerable, anxious and distressed, and we can alleviate all that naturally.

The Chair (Mr. Peter Z. Milczyn): Thank you. That's this section.

Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Thank you for your point of view. You brought forward ideas, I must say, that I had not thought about, so I want to thank you for coming to committee this morning.

I'm somewhat familiar with naturopathic doctors, but not as much as with other parts of the health care system. Do you know if, in any other jurisdiction, naturopathic doctors have the freedom of what you're asking for?

Dr. Nora Pope: I don't know the answer to that. Many of our patients live on and on and on forever. I shouldn't say that—

M^{me} France Gélinas: I think it's a good thing.

Dr. Nora Pope: Yes. I'm trying to think. I don't know. I come here as an individual and I come here as a patient and I come here as a medical practitioner.

M^{me} France Gélinas: I can tell that you have thought about this issue a lot. I will ask you the same question I ask everyone. Did you have a chance to be consulted by your provincial government, to have those views shared and listened to before coming here today?

Dr. Nora Pope: No, but I'm not a very—this is my first time at Queen's Park, so I'm not a lobbyist. I didn't know what room to come to. I was walking the halls back and forth. We couldn't find this room because it was written in script as opposed to numerical. I'm pretty green at this. But I did get some emails and I've been hearing about this and I decided, "Okay, I have an opportunity to speak," so I put my name forward.

M^{me} France Gélinas: So like most people, the conversation about MAID took place in social media, but we never created that safe place for people to bring good ideas forward so that we could find the middle ground that respects the ask that you've put forward and respects the right of people to have access to MAID.

The last piece that you were talking about to my colleagues, how do you see this moving forward?

Dr. Nora Pope: I don't quite understand your question, I'm sorry.

M^{me} France Gélinas: What would you like us to do?

Dr. Nora Pope: I want conscience rights protected. Naturopathic medicine was created over 100 years ago, but it had a rebirth in the 1950s in Oregon. Oregon has legislation which protects conscience rights; Belgium and the Netherlands do. So it can be done. There's always a solution. I think this will show that government can address all of society. I feel like a minority right now, so I'm asking for my minority rights to be protected.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser, you have three minutes.

Mr. John Fraser: Thank you very much for being here today. For your first time at Queen's Park, you're doing great. It's really good that you made the decision to come here and talk to us about conscience rights, because you're right: It's conscience rights that you're talking about here; it's not specific to any one group or another.

I would like to touch on something that you mentioned earlier: palliative care and end-of-life care, which is a mandate that I'm lucky to have inside government. Just in your experience, in terms of your work, as it relates to what we're talking about here today—I don't know where you practise, but if you could let me know a little bit about that, that would be great.

Dr. Nora Pope: I've been practising since 2002 in Toronto. For 15 years, I was working at a clinic in the Yonge and St. Clair area, with chiropractors and other naturopathic doctors. For the last year and half, I've been

working in private practice at a home office of mine. I have a very diverse patient base. I specialize in chronic care, people with chronic conditions.

Mr. John Fraser: Okay, so a lot of chronic conditions. In terms of your connection to palliation, are you connected directly with a team?

Dr. Nora Pope: No.

Mr. John Fraser: So you just do that through your own practice?

Dr. Nora Pope: Yes.

Mr. John Fraser: Is it something that occurs—you just said that your patients live a long time. But palliative isn't necessarily just end-of-life; it's longer. So in terms of your patient mix—

Dr. Nora Pope: Like I said, what I was trying to allude to is that a symptom can have any kind of root cause. If I'm dealing with depression or anxiety or distress, I have to be a detective—that's my duty—and try to uncover what's causing the distress in the person. It's not always physical pain. So though it appears that MAID is there for compassionate reasons, my fear is that it's there to expedite suffering. Suffering can be alleviated if you know the tools. It needs expertise, and that's why I really support palliative care.

But also, if you're in a state of distress, how can you make the best decisions moving forward for your treatment? That's why I don't want to be pushing my patients in that direction. I don't want to do it, because I don't want them to feel rushed into an unnatural death. I want them to—

Interjection.

Dr. Nora Pope: What's wrong?

Mr. John Fraser: No, it's okay. I was just checking the time there.

Dr. Nora Pope: Yes, sure.

But if they choose it, I will support it. Just like Quakers don't stop war, I'm not going to stop people's desire for assisted dying.

Mr. John Fraser: It's a very important piece of this puzzle that we have in front of us right now.

The Chair (Mr. Peter Z. Milczyn): That's all of our time. Thank you, Dr. Pope, for coming in today. If there is anything further you'd like to submit in writing, you have until 6 p.m. on Thursday, March 30.

Dr. Nora Pope: Does everyone have a copy of my notes?

The Chair (Mr. Peter Z. Milczyn): Yes, we do.

Dr. Nora Pope: Okay, great. Thanks.

END OF LIFE PLANNING CANADA

The Chair (Mr. Peter Z. Milczyn): Our next witness is End of Life Planning Canada. I just want to make members of the committee mindful of the time. We might not have time for questions.

Good morning.

Ms. Maureen Aslin: Good morning.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation. If you could please state

your name for the official record as you begin. I'll just caution you that we might not have time for questions of you because, under our standing orders, we have to stop at 10:15.

Ms. Maureen Aslin: Sure.

Thank you very much for having me here to speak. My name is Maureen Aslin. I'm the executive director of End of Life Planning Canada. We're a national charity that helps Canadians navigate the end-of-life experience with confidence and dignity. We promote research and provide information, education and support to help individuals and their families to plan for a gentle and dignified death, and to navigate health care with confidence that their rights and preferences will be respected to the very end.

End of Life Planning Canada is particularly focused on the needs of people who face systemic barriers to accessing care: people with low incomes; lesbian, gay, bisexual, trans and queer people; seniors; and racialized people. It is those voices that we work to bring forward.

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Overall, we support Bill 84 and agree that protecting privacy for patients, immunity for physicians and nurse practitioners, and protecting the rights to benefits and insurance for survivors, are good and necessary, but we do wish to express concern with two key issues.

First, there is nothing in Bill 84 specifically about referral by physicians who are conscientious objectors to assisted dying. End of Life Planning Canada supports the College of Physicians and Surgeons of Ontario's effective referral policy, which requires physicians who conscientiously object to assisted dying to refer patients requesting MAID to another willing provider or agency. But even with this policy in place, we've heard of doctors refusing to provide a referral.

This is precisely the time when, as a compassionate society, we should be offering support to allow the dying person the peaceful death and their loved ones the space to attend to the dying person and their own grief. Instead, this leaves patients and their families scrambling to find a willing provider to fulfill the person's request for MAID and alleviate the suffering of their loved one. To ask a dying person or their spouse, family or friend, who is in a state of anticipatory grief, to exert this effort at this time, we feel, is cruel and unnecessary.

I'll ask you to take a moment and try to imagine being in a state of suffering so bad that death is an attractive alternative. Your ability to take care of your own needs is diminished, long gone. Your caregivers bathe, feed and toilet you. The small things that gave you pleasure, like looking out the window, watching people walk down the street, seeing trees—the simplest things are now not possible. You find visitors and people who once gave you joy exhausting. Your pain is not manageable, and the side effects of the medications make life unbearable. Your family is tired and sad, and you are worried about them and the toll that this is taking on them. You decide that enough is enough, that things will only get worse from here, but now you learn that your treating physician

will not assist you in dying and suggests you find another doctor.

Now imagine that same scenario as a frail LGBTQ senior in hospital with no family, because the family is no longer speaking to them because they object to their homosexuality, and your friends have all predeceased you. How do you find a willing health provider? Do you go on Google? Not a likely thing.

Self-referral mechanisms are essentially an abandonment of patients who are literally on their deathbeds. It is important to note that as physical and mental capacities diminish, the barriers to equity in care become more difficult to overcome.

We think that CPSO's effective referral policy does a good job of upholding both patients' and doctors' rights, and we hope that this continues to be the standard.

In addition, we think that physicians should be required to make their conscientious objector status publicly known, so that patients can have this information as they look for a physician, or if they are already a patient and they do not know this information in advance.

Second, the involvement of the coroner's office presents other social difficulties for people. People requesting MAID and their families will not know if there will be an investigation until after the death is reported to the coroner. This creates a barrier in that many people may be reluctant to expose their family to that additional stress in the midst of one of the most difficult times in their lives, when they are grieving their loved ones.

My understanding is that the cause of death listed on the death certificate is suicide, and also, from a family perspective, this adds the burden of stigma. To avoid this, we suggest that there be a different practice that is enacted.

I'd like to close with a quote from Stephen Levine, who is an American poet, author and teacher best known for his work on death and dying over many years: "A death in character is a death with dignity."

It is important that we acknowledge that there are as many ways to die as there are humans, and that choice, up until our final breath, gives meaning and dignity to our lives.

Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much. Given the time, we do not have time for questions of you. If you do want to submit something in writing to the Clerk, you may do so until 6 p.m. on Thursday, March 30.

If there are no other items of business, committee is recessed until 2 p.m. this afternoon.

The committee recessed from 1015 to 1400.

The Chair (Mr. Peter Z. Milczyn): Good afternoon. We're meeting for public hearings on Bill 84, An Act to amend various Acts with respect to medical assistance in dying. The format for this afternoon will be that each witness shall have up to six minutes for their presentation, which will be followed by nine minutes of questioning from the committee, which will be divided up into three-minute segments for each caucus. The first round of questioning this afternoon will go to the New

Democratic caucus. Are there any questions before we call up our first witness?

DYING WITH DIGNITY CANADA

The Chair (Mr. Peter Z. Milczyn): Our first witness this afternoon is Dying With Dignity Canada. Hello.

Ms. Shanaaz Gokool: Hello.

The Chair (Mr. Peter Z. Milczyn): If you could please state your name for the official record as you begin.

Ms. Shanaaz Gokool: Shanaaz Gokool, CEO of Dying With Dignity Canada.

I thank the Standing Committee on Finance and Economic Affairs for including our organization at this hearing. We thank the government of Ontario for its leadership on assisted dying and for tabling Bill 84.

Dying With Dignity Canada is the national organization committed to improving quality of dying. We represent the 84% of Ontarians who support the Supreme Court of Canada's decision in Carter. We are a person-centered advocacy organization and we work to ensure that medical assistance in dying—MAID—regulatory and legislative frameworks are fair and compassionate, and do not cause further harm to people whose health is already severely compromised.

While Bill 84 contains a number of good amendments such as protecting health care providers and others in the lawful provision of MAID, protecting existing insurance policy agreements and protecting the privacy of individuals and clinicians, we do have concerns that I will highlight today and that are more detailed in the written submission that you all have in front of you.

Our primary concern in the draft legislation is that it allows public health care facilities to be exempt from freedom-of-information requests under the cover of privacy. Of course we support the privacy of individuals and health care practitioners, but we do not believe that public health care facilities have a right to hide their policies. These are public institutions that receive public funds to deliver public health care. MAID is part of public health care. People and their families have a right to know which health care facilities in their communities provide assisted dying and which do not.

In democratic societies, freedom-of-information requests are a critical tool for civil society organizations to hold government and public agencies accountable to their citizens and residents. In our circulated materials you will find a few stories that were generated through freedom-of-information requests by our organization. They illustrate gaps in MAID service that, without this freedom-of-information mechanism, we would not be able to shine a light on.

In Bill 41, the Ontario government has already overridden patients' rights in favour of institutional rights by allowing religiously affiliated hospitals to opt out of providing services that are contrary to their religious beliefs. This committee now has the opportunity to actually put patients first by striking the facility exemption and ensuring that Ontarians will know which health care

institutions in their communities support their charter right to an assisted death.

The requirement in the legislation that all MAID deaths must be reported to the coroner's office is highly problematic. MAID deaths are not sudden or suspicious, and the coroner requirement further stigmatizes assisted dying, the people who have an assisted death and the clinicians who assist in that provision.

The involvement of the coroner may also cause undue hardship and burden on the families of patients since they will not know until after the assisted death has been reported whether an investigation will be triggered. This is unnecessary and may be very, very difficult for families who are grieving such a recent loss. You can look at our submission for more details.

We ask that this provision in the legislation be struck and replaced with a post-review reporting mechanism that is coordinated with the federal health ministry.

Over the past few weeks, there has been significant debate in the Ontario Legislature during the second reading of Bill 84, on the issue of conscience rights. If this committee decides to write into Bill 84 a clause on conscience rights, we strongly recommend that such a clause should reflect a fair balance between a patient's right to compassionate care and a physician's right to conscience or religious objection.

I would ask each of you today at this table to consider the person who is requesting information on or requesting an assisted death. Think of that person in a palliative care facility or hospice care, whether it's in a community environment or in a facility, or maybe they're in long-term residency; the person who may be so physically compromised that they're not able to pick up the phone and make a phone call to find help, the person who is not able to navigate a website on their own without support.

That person may not have family or friends to advocate for them, perhaps because they're just incredibly private and they're trying to protect their family from the difficult decisions that they are going to be making in their journey towards death, but perhaps because they simply will not have family or friends to advocate for them. We have all heard the stories, and I'm quite certain that no one at this table is under the illusion of what happens when a gravely ill person does not have access to help.

This person that I've just described is our North Star on this issue. Their situation must inform any policies or laws about conscience rights. Of course we support individual conscience rights—as a human rights organization, we hold those rights dear—but we cannot consider policies or laws that do not consider our most vulnerable, frail and dying person: our North Star.

These are people who, if they choose and are eligible, have a right to an assisted death, but rights aren't absolute, and we must find a fair reconciliation that will balance the rights of the clinician who has a conscience or religious objection, and the charter rights of the person who, if they're eligible, has a right to an assisted death.

We believe that the MAID policy of the College of Physicians and Surgeons of Ontario strikes a fair and compassionate balance by requiring physicians who object to provide an effective referral for MAID-related services. We urge the committee and the government to support this policy as the gold standard.

Without this policy, people may be delayed and forced to endure more unnecessary suffering. They may lose capacity during that delay, and ultimately therefore lose their right to an assisted death, or we're simply never going to know who they are—the unfortunate ones who were not able to self-refer. In Ontario, we can do better than that. Today—

The Chair (Mr. Peter Z. Milczyn): Thank you. That's your six minutes.

Madame Gélinas, you have three minutes.

M^{me} France Gélinas: If you don't feel comfortable answering my question, I don't want you to feel that you have to because you're sitting here, or anything like that.

Ms. Shanaaz Gokool: Certainly.

M^{me} France Gélinas: But certainly other organizations have put forward how they want to avoid the effective referral, and they want to have a system in place of case coordination that would be accessible to all, including the patients. Have you looked at this? Do you know what I'm talking about, and do you have an opinion on that?

Ms. Shanaaz Gokool: I do have an opinion. I have looked at it. It's very similar to what has happened in Alberta and how they've implemented medical assistance in dying. They have a self-referral system, and there are people, if you can find them, who will be able to help coordinate your service and be able to help you find another practitioner.

But I think that the bar that we have to set is for that person, who is alone, who may be in hospice care, who may be in an institution that objects to providing assisted dying, who has no one to do that for them—how are they going to make it known that they want to have their questions answered, or to be able to have an assisted death if they qualify? The thing with the Alberta system of self-referral: We'll never know. We don't know who those people are, because they don't have anyone coming forward and advocating for them. But what we do know from across the country by people who've contacted our organization is that there are people who are forced to endure unnecessary delays when they are in places or when their physician or their health care provider does not want to provide them with an effective referral. We do know that in that delay, you can lose capacity, and under the federal legislation, you have to have capacity at the time of receiving assisted death, or else you'll be denied.

I think if we're looking at who we need to set the bar for, it has got to be low enough for the most physically compromised to be able to reach up and grab it.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser, you have three minutes.

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Mr. John Fraser: Thank you very much, Ms. Gokool, for being here again today. I saw your presentation on Bill 41, and I want to thank you for your work and your advocacy.

You didn't get an opportunity to speak very much with regard to an access problem for some of the things that you described in here. Did you want to take that opportunity to describe the situation?

Ms. Shanaaz Gokool: Yes. There are a number of issues related to access all across the country and certainly in Ontario. If you don't have the ability to receive an effective referral, you may end up in a situation where you can't find a provider to help you because you yourself are unable to find one.

We have had people contact our offices. We have a personal support program where we've tried to assist people who are in these circumstances in Ontario, so we know that it's happening here, even with the college policy on effective referral. But we also know that there are access issues related to the number of providers in the province. The provision of having all MAID-related deaths go through the coroner's office—I believe that the province of Ontario is in this position because the federal government hasn't done their work according to Bill C-14 and coordinated effective reporting, so Ontario is left with trying to find a system, and it's the coroner's office.

The problem with the coroner's office is that there's an additional amount of paperwork and bureaucracy. You don't know, as I mentioned, if an investigation will be triggered. What that does is it acts as a disincentive for providers to want to be involved in what is already a very sensitive and emotional area of practice.

Mr. John Fraser: How much time do I have?

The Chair (Mr. Peter Z. Milczyn): One and a half minutes.

Mr. John Fraser: One and a half minutes. Thank you very much.

I heard your response to Madame Gélinas with regard to a patient-facing care coordination service. We were just talking about access right now. So in terms of an access point—and I made this description earlier today: There may be situations that people find themselves in, where seeking that information is not something that they want to necessarily share with their provider or with their family. I'd like your opinion on that, in terms of how you see that. I know that we've talked a lot about privacy and protection of practitioners.

Ms. Shanaaz Gokool: Yes. I'm sure there are people who may already have a sense of how their doctor or nurse practitioner might feel about medical assistance in dying and that they may ask questions, and they may not feel as comfortable. But I think that they have to be able to find the proper medical care and help and advice that they need. Most people, I believe, will go through their providers, even recognizing that they may not be supportive, but just to ask for help. Then it's the duty of the provider to be able to do that, as opposed to abandoning the patient in these circumstances.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, three minutes.

Mr. Jeff Yurek: Thanks for coming in and speaking today. Just a question—and I don't have the answer myself of why it's in this bill regarding identifying information for institutions, why it's not accessible. I would think maybe it's in there so it would decrease the amount of demonstrations and protests at those facilities that do provide medical assistance in dying. Have you thought about that type of repercussion, why they wouldn't want to share that information?

Ms. Shanaaz Gokool: It's a good point. The actuality is, we've launched a campaign. It's called "Shine a Light." We've asked our supporters all across the country to check in their communities, hospitals and hospices on who's providing and who's not. We've got a Google map on our website, where we're mapping it out, so we can have a better understanding of what's going on. What we found is that the facilities that are providing are very happy to share the information about what their policies are and the protocols and how it works. The ones that are not providing, however, are very hesitant, and we haven't seen any policies or protocols.

In terms of the safety issue, there's more safety in numbers. If everyone across the province is providing assisted death, you really can't target any one facility or hospital. It doesn't mean that every place will necessarily have assisted dying, depending on circumstances or time of the year. It just means that if everyone is providing, there's far more safety in numbers.

Mr. Jeff Yurek: Have the LHINs been at all helpful in helping identify any—

Ms. Shanaaz Gokool: Some. We have filed a number of freedom-of-information requests since the winter. You'll see in one of the articles that we have provided—and I believe it's the Erie-something LHIN; I can't think of the full name.

Mr. Jeff Yurek: St. Clair.

Ms. Shanaaz Gokool: That's it. They didn't have policies in place, and there was a situation where someone who was terminally ill was being transferred, and there were problems with that transfer. In the end, the person didn't have an assisted death. There were problems between two facilities over a coordinated strategy which did not work. But it did prompt that LHIN to start putting together a MAID implementation team and put those policies and protocols together.

So I think there's a lot of unevenness and inconsistency just across this province in terms of LHINs, hospitals, hospices, long-term-care residences, being ready for the inevitable request, which may just be questions before an actual request for an assisted death. I think that's the opportunity that the government has: to ensure that there is a strategic, coordinated system in place so that it doesn't matter if you live in Toronto or if you live in northern Ontario; there is a clear pathway to be able to have your questions answered and to be able, if you're eligible, to access an assisted death.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much for your presentation today. If there's something further you'd like to submit in writing, you can do so until 6 p.m. on Thursday, March 30.

Ms. Shanaaz Gokool: Thank you so much.

HIV AND AIDS LEGAL CLINIC ONTARIO CANADIAN HIV/AIDS LEGAL NETWORK

The Chair (Mr. Peter Z. Milczyn): Our next witness is the HIV and AIDS Legal Clinic Ontario. Good afternoon. You have six minutes for your presentation. Questions will start with the government caucus. If you could please state your name for the official record as you begin.

Ms. Amy Wah: My name is Amy Wah and I'm a staff lawyer at the HIV and AIDS Legal Clinic. I fill the policy position there.

I'll be speaking today on behalf of two organizations: both our clinic and the Canadian HIV/AIDS Legal Network, jointly. First, I'll tell you a little bit about our organizations and explain why we're here today and then speak to you about our particular concerns with Bill 84.

The HIV and AIDS Legal Clinic Ontario, which I will refer to by the acronym HALCO, is the only community-based legal clinic in Canada serving low-income people living with HIV, through legal advice and representation, public legal education, law reform and community development initiatives. Since its inception, we've handled over 50,000 inquiries for legal assistance, delivered hundreds of workshops, presented numerous briefs to various government committees like yours, and intervened in matters at courts of all levels, including the Supreme Court on nine occasions.

The Canadian HIV/AIDS Legal Network, which I will refer to as "the legal network," is the only national organization in Canada that works exclusively on legal and policy issues relating to HIV and AIDS. It is one of the world's leading expert organizations in the field, with an extensive body of human rights-based research and analysis on a range of issues related to HIV. They have quite a lot of involvement at the UN level as well.

Why are we here? Since the beginning, people with HIV have been concerned with bodily autonomy. This includes the right to access health care without stigma and without discrimination. "Nothing about us without us" articulates a GIPA principle; in other words, greater involvement of people living with HIV/AIDS. This was started by people living with HIV in the early 1980s at the outset of the AIDS epidemic, and formalized in 1994 at the Paris AIDS summit, when 42 countries agreed to support the greater involvement of people living with HIV and AIDS at all levels and to stimulate the creation of a supportive political, legal and social environment.

The work of both our organizations aims to ensure that we promote this principle in law and in policy-making at all levels of government, including Legislatures and in courts. This is the reason why our organizations jointly

intervened in *Carter v. Canada* at the Supreme Court, which led to the availability of medical assistance in dying, or MAID. We presented the perspective of people living with HIV, a complex and deeply stigmatized medical condition, and supported the position that it should be made available—more specifically, that the criminalization of assisted death that denies access to this is constitutionally impermissible. As you know, the court agreed with that position, and Canada amended the Criminal Code. So here we are.

Just a couple of points we want to focus on with this bill: First of all, I want to indicate our support for Dying With Dignity's submissions regarding coroner involvement in MAID. Now I want to talk about the proposed amendments to the privacy legislation, PHIPA and MFIPPA. We are also concerned about the proposal to exclude public access to information about MAID relating to facilities.

While we, of course, support privacy protections for individuals requesting or accessing MAID, it's not in the public interest to shield hospitals and other publicly funded facilities through these proposed amendments.

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Ontario has already enacted legislation—referred to by Dying With Dignity as well—Bill 41, which provides special protection for these publicly funded, faith-based hospitals and facilities against any directives given by the minister, through LHINS etc., that would require them to provide a service—the bill itself only refers to a service, but this would, of course and most certainly, include MAID—that is contrary to the religion related to the organization.

While we take very seriously the charter right to freedom of religion and conscience, we think this amendment is wrong. However, if publicly funded facilities are given government sanction to refuse to provide MAID, Ontario needs to balance any conscience rights against the rights of patients to access MAID.

Let me explain why the proposed amendment is wrong. When hospitals are opaque about their stance on MAID, particularly hospitals that refuse to provide this service, patients are not able to determine whether they can access that until they're in the hospital. It's vitally important that individuals, who wish to access MAID either directly or prospectively, have the information necessary to do so.

When a person—and Dying With Dignity covered this very well—falls gravely ill, when they become legally entitled to access MAID, they may not be in a position to advocate for themselves, let alone organize a transfer or locate an appropriate facility or practitioner. In some cases, in smaller communities, this might mean travelling hundreds of miles.

We support public access to these hospital policies so individuals can properly plan and make informed decisions in regard to access to health care. There's currently an application before the courts, challenging the CPSO's—the College of Physicians and Surgeons of

Ontario—policy on mandatory referrals, where a request for MAID is denied.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Wah. That's all the time.

Mr. Fraser, you have three minutes.

Mr. John Fraser: If you have something left in your presentation, please continue.

Ms. Amy Wah: Oh, thanks.

We are jointly applying to intervene in that particular matter. If we're allowed to participate and we're accepted as intervenors, we'll argue that, if the charter entitles physicians to limit medical services that they provide for reasons of conscience or religion, then they must provide an effective referral and, in fact, they should provide the service in an emergency situation, as with other medical treatments.

It can't be controversial that it's near-impossible for a patient to access a second opinion or diagnostic or treatment services when their primary physician is reluctant or refusing to provide the treatment; I imagine that's quite difficult with a serious illness like cancer or heart disease—treatment for that—but imagine how difficult that can be when you're seeing a still socially stigmatized medical service like MAID.

Mr. John Fraser: Two minutes? Okay.

Thank you very much, Ms. Wah, for being here today and for your presentation and for the work that you do in advocacy for people with HIV and AIDS. Your presentation was very good.

As we go through this—and I've mentioned this a few times before—the pathways for people to get the service are critical. I appreciate your comments around recognizing the balancing of rights or finding a way forward on that.

I just simply wanted to say that to you and thank you for your presentation. I don't really have any specific questions. It was very clear as to your position on certain things. We appreciate you very much for bringing that here. Thanks very much.

Ms. Amy Wah: Okay—

Mr. John Fraser: Would you like to say something? Sure.

Ms. Amy Wah: I have a comment about access that was raised by Ms. Gokool. This idea that we have out access to these services differently than we would other health care treatments—I urge you to consider some of the ramifications of that. It might be stigmatization and, in fact, it might be more barriers to access.

Everyone generally accesses health care through their doctor, their primary service provider, and they should be able to take that same path and have that same care in terms of problem-solving for them, how to get the treatment they're seeking, that they're legally entitled to.

Mr. John Fraser: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Just basically one question that maybe you can elaborate more upon: You mentioned that you support Dying With Dignity's section with regard to

reporting to the coroner's office. It was briefly mentioned that perhaps the federal government is behind the eight ball in creating a reporting system. Would you concur with that? What avenue should be taken to avoid having to report everything to the coroner?

Ms. Amy Wah: I should say up front that neither of the organizations I'm speaking on behalf of today have taken the initiative to think perspective as much as Dying With Dignity in terms of what logistically could work. I would take this opportunity to emphasize that certainly the uncertainty with regard to investigations by the coroner and capturing these kinds of deaths as suspicious or warranting further investigation could have this disincentive factor that was raised.

It is, on the other hand, extremely important to capture data about who is requesting—not necessarily personal information, but the types of populations that are requesting this; underlying illnesses; the outcomes of those requests; who is able to access them; when they're getting referred; how many times are they getting referred etc.

I know that New Brunswick is starting another initiative that is taking it out of the coroner's office as well. There are other jurisdictions to consider in terms of how it's done. Quebec has been at this for longer than other provinces. There certainly may be alternatives that will promote access in a way that would avoid the problems that coroner's office involvement might raise.

Mr. Jeff Yurek: So would you think to remove this part of the bill until a situation is created or a process is created—otherwise, we'd have to revisit this legislation and change it again?

Ms. Amy Wah: Yes. I think that would be wise counsel. From my understanding, even without this, the coroner's office is involved. So it's not going to stop that from happening; it doesn't need this amendment for that to be in place until some other system is put into place.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Have you given some thought and have you put anything in writing as to what kind of information should be kept so that we learn from this and get better?

Ms. Amy Wah: That is an excellent question. I would like to take the opportunity to follow up in writing, if possible, to the whole committee. I will endeavour to do that.

Just some remarks off the top: I certainly think it's important to be in a position where we know how many people are asking. It's important, when we're thinking about doing our due diligence in regard to this data, that we're not setting up a roadblock to even getting the beginning of that data: Who is interested? Who feels comfortable speaking to a health care practitioner? Without making sure all the barriers are down, those statistics will not be representative of the realities out there.

M^{me} France Gélinas: For the population that you serve, specifically HIV and AIDS, has there been a forum

for them to have a dialogue on this? How do you know that it is important to your members, to the people you serve—sorry, not your members, but the people you serve?

Ms. Amy Wah: We actually have members as well, but they're not exactly the same group of people who are clients. Clients can access our services without being members, and people can be members without being clients.

We are open for questions four days a week, 9 to 5. Anyone living with HIV in Ontario can call us on the phone, come into our office, send us an email, and put forward their legal question. We manage to collect a lot of information through that service provision, and we get a lot of details about people's lives and the legal issues they're challenged with and what services they desire to access. While we may not have done a community survey per se—not that we would be closed to doing that, of course, or facilitating that—we can certainly operate on that information that comes to us through legal inquiries.

M^{me} France Gélinas: Would you say that you had some, quite a few or lots of people reaching out to you about MAID?

Ms. Amy Wah: There has certainly been a lot of curiosity, as you can imagine, as to how the monopoly of medical options has expanded. This has been an issue that has been in the news for a long time. People living with HIV/AIDS have always been encouraged to plan for illness, and this is a really, really important part of doing that planning. I can confirm that of course there has been great interest. I've given a workshop on the legalities of it. It has been open to community members; it was well attended. There were a lot of questions. It's new to everyone, but it's really important that people have enough information and feel comfortable enough that they appreciate that it is something that is an option in planning for illness.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Wah, for your presentation. If you do want to submit something in writing, you have until 6 p.m. on Thursday, March 30 to submit it to the Clerk.

Ms. Amy Wah: Okay. Finally, I really want to thank the committee for this opportunity to speak to you.

B'NAI BRITH CANADA'S LEAGUE FOR HUMAN RIGHTS

The Chair (Mr. Peter Z. Milczyn): Our next witness is B'nai Brith Canada's League for Human Rights. Good afternoon.

Dr. Janice Halpern: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation. The questions will start with the official opposition. If you could please state your name for the official record as you begin.

Dr. Janice Halpern: My name is Dr. Janice Halpern. As a psychiatrist, I see many patients who tell me that

they want to die. Most of the time, I discover that they want me to do my best to help them choose life and to live their lives well. They need to know that I share those goals and that they can trust me to stand firm and not prescribe death when they temporarily succumb to their despair.

My patients know that even if they feel frightened or lonely or despondent or overwhelmed, we can tolerate these painful feelings together. I am witness to their suffering, and we will emerge on the other side of this difficult time.

I tremble, however, when I consider that, someday, a patient may walk into my office requesting medical aid in dying, because then my medical governing body has the power to force me to refer the patient for MAID. This would amount to me knowingly participating in my patient's death. I would try my best to explore the meaning of her wish to die. However, if she still wanted to be killed, I would be forced to refer her to the queue, the queue where she would be assessed for MAID. The assessment is not hard to pass: The patient can't be under duress, must be mentally competent and her primary diagnosis must not be a mental disorder.

How long am I allowed to work with her on finding her will to live again? My regulatory body says that this must be done in a timely manner. I am required to not impede her access to death, but some patients need more time.

I know what the law requires of me. I will gently inform my patient of all her choices and how she can access them. However, to make me a party to her death by forcing me to refer her directly to that queue—that far, I cannot and I will not go.

The college's requirements of the patient, which are to recover quickly or die, and of me, which are to heal her quickly or be complicit in her death, are too harsh. This is how the law stands now, and it's unfair to both my patient and to me. It puts us both under enormous pressure. If I fail to refer, my regulatory body has the right to sanction me with anything from public humiliation to re-education, to fines, to losing my licence to practise medicine, all because I tried hard to keep my patient alive.

If I do refer, I have to live the rest of my life knowing that I made that choice, that I was willing to forfeit my patient's life in order to save my livelihood.

Participating in killing my patient, in my mind, is a heinous act. My conscience is something very real. It's an integral part of me, honed through years of moral education and professional experience. It's also something that is capable of torturing me.

I have had the experience of having a patient dying unnecessarily on my watch. It took place when I was an intern on a medical ward. There was a very sick patient there who suddenly became sicker. The staff physician was out of town, and the senior resident decided to take the day off and go golfing. I was alone. I tried my best. The woman died. To this day, it takes very little for that whole fiasco to rise up before my eyes in technicolour.

That was tough enough, but participating in killing, putting my need to keep my job first—none of you would want that on your conscience.

In fact, in the 1960s, our Supreme Court decided to abolish capital punishment. Why? Because they felt it was too great a responsibility. What if they made a mistake? They gave themselves the right to not have to make those decisions. But what about physicians? What freedom do we have? What rights do we have?

I admit it: I'm a physician with a conscience. I want my patients to have the best possible opportunities to remain alive. Amending Bill 84 is the ideal opportunity to deal fairly with all physicians: not just the ones who need protection when they kill patients, as is already in the bill, but also the ones who want to keep their patients alive and give them more time and another chance.

We need protection from our own regulatory body, which is demanding something that no other province and no other country requires of their physicians: mandatory referral.

Bill 84 should provide conscience protection for physicians. The Supreme Court requested, and our federal government reiterated, that the rights of patients and physicians should be reconciled. Everyone else has done it. It can't be so difficult.

With the simple addition of conscience protection and a central service that patients can access, Ontario will finally be back in line with the rest of the country and with Canadian values. It will remember how to be a democracy once again.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Halpern. We'll start with Mr. Yurek, for three minutes.

Mr. Jeff Yurek: Thanks for coming in, Doctor, and giving your time to speak to the committee.

It's interesting that you mentioned that the college may re-educate you if you stick with your conscience. Is it even possible to re-educate someone on their own conscience?

Dr. Janice Halpern: I don't think so, but they might try.

Mr. Jeff Yurek: You mentioned that other jurisdictions don't penalize doctors for believing in their conscience rights. I think we've mentioned it in debate—

Dr. Janice Halpern: They don't require it of them.

Mr. Jeff Yurek: They don't require them to do it.

Dr. Janice Halpern: No.

Mr. Jeff Yurek: But I believe there are protections in Oregon and in places in the States that say you can't discipline a doctor for not providing assisted dying.

Dr. Janice Halpern: Right.

Mr. Jeff Yurek: It's interesting that we're the only place that is doing that. I've spoken to CPSO, and they're not going to be changing their mind. They're sticking with effective referral, so it's kind of challenging the Legislature to fix this invasion of someone's rights. Do you have any comment on that?

Dr. Janice Halpern: Yes. We need your help.

Mr. Jeff Yurek: Would you say that this piece of legislation is the one time to deal with conscience rights?

Dr. Janice Halpern: I think it's the very best time. I think this is the time to do it.

Mr. Jeff Yurek: My last point is a question that has been brought up numerous times, and I ask any of the health professionals who show up here. Many will say that you're abandoning your patients when you're not offering medical assistance in dying. Is that true? Or if there was a referral system set up by the government, much like Alberta, would patients be abandoned and left on their own?

Dr. Janice Halpern: That's right. I think the Alberta system is excellent. I think it would work very well.

When you talk about abandoning our patients, when you look at all the colleges of physicians and surgeons from all the provinces, only Ontario put side by side, "You must make an effective referral" and "You will not abandon the patient." They are the only ones who have set that up. Nobody has ever said before or since, that I know of, that refusing to do a referral is abandoning the patient.

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Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas for three minutes.

M^{me} France Gélinas: I'm interested in the conversation you were just having. You are the first to bring forward the fact that you think that the eligibility criteria are not clear enough or stringent enough. Just quickly, they say:

- have a grievous and irremediable medical condition, which means to have a serious and incurable illness, disease or disability;

- be in an advanced state of irreversible decline;

- be suffering unbearably, physically or psychologically from illness, disease, disability or state of decline; and

- be at a point where natural death has become reasonably foreseeable.

What else would you like to see there, to reach the bar where you would like the bar to be set?

Dr. Janice Halpern: I don't know where it would be put, whether it would be put in that list or whether there would be a requirement that the patient has had an in-depth conversation about why they want death, especially people in emotional pain, who are the ones who show up in outpatient departments or my office. What is their suffering about? Are they lonely? Are they grieving? Are they overwhelmed? There should be an opportunity that somebody can speak to that patient and can listen to that patient. It's not just if they fit a list of criteria.

M^{me} France Gélinas: I come from physical health; I'm a physiotherapist. I used to work with spinal cord injuries. I can tell you that almost every single quadriplegic I have worked with, in the early stages of becoming quadriplegic, they ask to die.

Dr. Janice Halpern: Yes.

M^{me} France Gélinas: They cannot face what has happened to them. But at the same time, they would never meet the criteria that are there. So if you think that

we should add criteria to make it more robust, I would certainly be happy if you could share that with us. We'll give you the timelines and all of that.

Coming back to the Alberta system, it has been shared with us and talked about a lot. You would be comfortable with this?

Dr. Janice Halpern: Yes, for the reasons that, first of all, they have in-depth discussions, if that's what the patients are willing to do. They offer a range. They offer the possibility to open the topic of end-of-life issues, so it's not simply a route that goes two directions—live or die, right? Or live, or get your MAID assessment and then see what happens. So there are a lot more options for a person, and some of them could be life, actually, which would make it easier for me, not to refer but to say, "This is a good place for you to go. You'll get taken care of here."

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser, for three minutes.

Mr. John Fraser: Thank you, Dr. Halpern, for being here and for your presentation.

The Supreme Court decision, whatever side you're on, is about compassion, mercy and love, no matter how we all interpret that from our conscience.

It's also about choice. Part of that choice is access to quality end-of-life and palliative care. We've done some things inside government to do that. There's a lot more work to be done, not just by government but within the health professions as well, and in our institutions, for our approach.

I know that you serve people who are suffering. I'm sure that you've had some with complex medical conditions. What are your referral paths for palliative care specifically, if you have a patient that you believe needs palliation?

Dr. Janice Halpern: That I believe needs palliation? I don't know that any of them have come to my office.

Mr. John Fraser: Okay. I thought that you had people with a dual diagnosis, where they've got a physical ailment as well.

I'll bring it back to the care coordination service, which has been mentioned a few times in here. I personally believe that as a patient-facing opportunity or point of access, it's important. Why do you think it's important?

Dr. Janice Halpern: Why do I think that is important?

Mr. John Fraser: Why did you raise that in your answer?

Dr. Janice Halpern: Because the way the system is right now, if a physician refuses to refer the patient, or if the patient doesn't have a family doctor or the patient doesn't want to talk to their family doctor about it, they have no place to go if I tell them I can't refer them. They're stuck. I think the way the system is now is a huge disservice to these patients. They have to be able to access it. Right now, their access is being impeded.

Mr. John Fraser: Okay. Thank you very much again for your presentation and your work.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Halpern, for coming in today. If you'd like to present something in writing to the committee, you can do so until 6 p.m. on Thursday, March 30.

Dr. Janice Halpern: Okay. Thank you.

DR. CHRISTINE CSERTI-GAZDEWICH

The Chair (Mr. Peter Z. Milczyn): Our next witness is Christine Cserti-Gazdewich. Good afternoon. You have six minutes for your presentation. Questions will begin with the NDP caucus following that. If you could please state your name for the official record as you begin.

Dr. Christine Cserti-Gazdewich: Thank you, dear audience. My name is Dr. Christine Cserti-Gazdewich. I am a blood science specialist, stamped indelibly by the Krever commission. I know the dangers of system silence. I serve as an associate medical director to the laboratories dispensing safe, compatible blood products to dozens of Ontario hospitals, some as far north as Attawapiskat. I am an assistant professor at a nearby medical school, with my primary appointments at the downtown teaching sites. I am also a clinician, treating disorders marked by self-destruction, bleeding, clotting, or malignant overgrowth. My research has delved into the evolutionary biology of diversity and how to overcome barriers to blood and organ matching. At the end of the day, and with my colleagues, I love my patients, and we share the honour of caring as best we can.

I'm also a secular humanist, a vegan environmentalist, and the daughter of east European immigrants. Half a century ago and a decade apart, each of my parents fled a regime where the game was unanimity. Personal experiences explain why I cannot thread the needle of MAID and why I hope for conscience protection in this land that my parents came to when they sought freedom for themselves and their children.

I was turning 20 when my mother was dying; she then was at an age similar to mine now. When I reflected on the sorrow we felt with her suffering and the disappearance of future decades together, I thought that if a crystal ball had shown me what we were about to go through, I might well have shot the both of us before shedding the first tear. But then I was so thankful for the blind and healing linearity of time, and for every moment in between. I also thought that if she had asked me to inject her with an agent endowed singularly with the property of arresting her heart or to find someone else to give it, I could not and that I would be honest with her as to why.

After MAID was legalized, I realized that if I could not abet the suicide of the greatest love of my life, then I could not do the same for a stranger, whose place in my own practice I aim to position as reverently as that of my own kin. This is not out of arrogance, but humility.

Some years later, I got married, and my spouse and I tried to become parents. For medical reasons, the ease with which life comes into the world was not ours to have. I say this sincerely: Life, to me, is a breathtaking

miracle in this mad universe. I know what it is to lose it, to hurt and to fail to channel it. I go to work every day joining others on similar journeys. But I fear that my values may soon be held against me when up to now they were an asset.

I am here to ask for two things: For patients to have the power to self-refer and for their clinicians to have the right to conscientiously refrain from MAID-related activity.

A care coordination service is a must. Some patients don't have doctors. I will tell you practically: If "effective referral" is something that you think materializes quickly, think again. Insinuating an MD—even the most energetic and agreeable one—is another discriminant between the haves and the have-nots, and a spacer between communication and action. Patients considering MAID deserve no less than the same direct access and discretion afforded to others in the midst of their most private crises of reproductive or mental health.

As for conscience, the right to reasonably object to a procedure may percolate valuably into other Gordian knots. My colleague may recuse herself from inserting a nasogastric tube into a pregnant political hunger striker if indeed force-feeding is the preliminary order of a few decision-makers. We owe honest feedback signals to our hierarchies in uncharted territory. When commanding these edges of life, conscience deserves respect, and James Downar would agree. Laws aren't mere instruments but cultural memoranda.

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Conscientious objectors are not insulting our patients if they are enabled to seek their own will. Some of us hold an equally logical counter-position on life-terminating compounds. Today, veterinarians have more experience with euthanasia than we do, and American executions of human beings have been botched in imitations.

Uncertainty begs for analysis and criticism. Conclusions in science and legislative decisions utterly depend on such debate. Free conscientious objection to MAID is what peer review is to science. It's something that reveals flaws and coaxes improvements. This constructive dialogue is not a bedside sword but the vitality of a system striving for excellence.

Prohibiting dissent and permitting disciplinary actions by licensing colleges will do this: bake a North Korean-styled moral Darwinism into Ontario. Only those who agree, and those too timid to disagree, comprise what remains.

Without amendments, we face quantitative and qualitative corrosion of our health care workforce. Scores of patients could flounder after default expulsions of their health care workers. Is such an effect preferable to the awkwardness of hinting at the sanctity of life?

I don't disagree that we clinicians must, and do, sacrifice a lot to promote the fulfilment of our patients' aspirations in the optimizable boundaries of their health. However, I don't believe that this mandates collaboration in actions that can induce the moment of death, the other side of which remains inaccessible to science.

Many also know that clinician well-being is an essential precondition to best patient care. How do we reconcile new guidelines to limit exhaustion with the simultaneous dismissal of our moral anxiety?

We cannot afford that which further increases the pitch of medical error, burnout, functional extradition or gagging that which compelled many of us to dedicate our lives to the sick.

Thank you for your attention.

The Chair (Mr. Peter Z. Milczyn): Thank you very much. Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Thank you for coming to Queen's Park. I was really touched by your remarks.

I will take the two recommendations one at a time in the short time that I have. The first one is to give patients the power of self-referral. The method that has been talked about the most here is what Alberta has brought forward. Does that meet the standard that you would like to see?

Dr. Christine Cserti-Gazdewich: It absolutely does. Women can seek abortions in an environment where many people object to them. You do not need a physician in between. You can do this privately. You don't have to involve parents, loved ones, anybody. Patients need direct secret or open access, but we need a well-known structure. The knowability of that will increase with time, but it needs to be organized. This is an essential structure, as many others have had to come to be for similar very contentious situations.

M^{me} France Gélinas: Can you describe to me what it would look like on the ground for you, as a practising physician?

Dr. Christine Cserti-Gazdewich: This is sort of like knowing what 911 is. This is a matter of physicians' training and the existence of this care coordination service and knowing the phone number. There are many ways that we message-market. There are posters. There are cards you can give to individuals—pamphlets. This could be part of an admission package to palliative care units. It needs to become such a thread of common knowledge in the end-of-life experience. Everyone deserves access to a care coordination service, one that's non-judgmental, dispassionate and capable of sorting patients through the pathway that they want for themselves, irrespective of the views of those around them. I think there is a way to separate this.

M^{me} France Gélinas: Okay. Do you have a view as to if hospitals or hospices could opt out as an agency versus as the conscience of a person?

Dr. Christine Cserti-Gazdewich: I can't speak to what I think entire institutions ought to do with this. I'm here really only to represent the individual practitioner. I think that in an environment where this accessibility is very public—I'm not sure how to answer your question with respect to the institutional approach, if an institution wishes to forfeit participation.

M^{me} France Gélinas: Fair enough. Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser, you have three minutes.

Mr. John Fraser: Thank you very much for being here today and for sharing a very, very personal story. I think it's important for the committee—for all of us—to hear that, as we're hearing many different things throughout the day. You may have heard earlier, I made some remarks around palliative care and the importance of that.

As a practitioner, though, are you directly—

Dr. Christine Cserti-Gazdewich: I am.

Mr. John Fraser: Okay. If I may ask, what are the pathways right now that you use for palliative care?

Dr. Christine Cserti-Gazdewich: It's very easy for me. I know the extension and how to page palliative care. There's locating, there's intranet, Web directory pages for the colleagues who are on service at the moment that I'm seeking them.

Mr. John Fraser: We did a series of consultations last year through the ministry. Defining that access is a critical piece.

Dr. Christine Cserti-Gazdewich: Yes, I agree.

Mr. John Fraser: So when you talk about the co-ordination of care, I can understand what you're saying. I think there needs to be, as you said, patient facing—and there is a commitment by the government to care co-ordination service. I don't know if you want to say anything more about the care co-ordination service. I think you were very clear about why you felt that was important.

I just want to thank you again for being here today. It's important that we hear from everyone we can to get the balance of things that are right. As a practitioner, you know that, and I know that you care for your patients and I know that you won't abandon a patient. It's how you create the space that makes that work. I want to thank you.

Dr. Christine Cserti-Gazdewich: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thanks for being here today. It was a powerful speech that you delivered. I would like a copy of it, if you're able to submit it. I will get Hansard, but I would appreciate that.

Maybe you can help me out here because my thinking is that you can have the patient referral care coordinator active but if you don't deal with the conscience protection, this is still an ongoing problem with the profession.

Dr. Christine Cserti-Gazdewich: Absolutely. There are two parts to this.

Mr. Jeff Yurek: There are two parts to this. So you can have both but it doesn't fix the problem that is experienced in health care.

Dr. Christine Cserti-Gazdewich: Effective referral still renders many complicit, in their view, with the continuum of care that culminates in the lethal injection or whatever the mechanism is to achieve death.

Mr. Jeff Yurek: Are you able to comment on the stress that's causing your colleagues or yourself or others that you've seen in your life?

Dr. Christine Cserti-Gazdewich: Thank you for that question. I'll tell you, it's sometimes difficult to sense that because the promotion of this service's availability

has such a tone of bias that I see in my own trainees—and I do train a lot of young physicians. It's virtually impossible to hear anyone express any dissent. I've had, however, trainees come to me, and I'm not sure how they would guess that I have my views because they're not coming from a religious place. But they have expressed some discomfort to me. This even includes academic half days on palliative care in a hematology-oncology training program.

There are very few people who—if they have this view, we wouldn't even know it. It's sort of like the American election and how the pollsters got it all wrong. I think we don't know what people are really thinking, and I'm sure that has a lot to do with the context of how the question is delivered and how that information would seem to be shared thereafter.

Mr. Jeff Yurek: I think it's healthy, not only in health care but in our community as a whole, that we allow these discussions to occur without fear of reprimand. I think it's sad that we're at that state where people are afraid to bring their feelings forward and have that discussion.

Dr. Christine Cserti-Gazdewich: I absolutely agree.

Mr. Jeff Yurek: Thanks very much.

Dr. Christine Cserti-Gazdewich: Thank you, everyone.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor, for coming and sharing your thoughts with us today. If you do want to submit your remarks in writing or anything else in writing, you have until 6 p.m. next Thursday, March 30, to do so.

DR. BETTY-ANNE STORY

The Chair (Mr. Peter Z. Milczyn): Our next witness: Betty-Anne Story. Good afternoon.

Dr. Betty-Anne Story: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation, and if you could please state your name for the official record as you begin.

Dr. Betty-Anne Story: I'm Betty-Anne Story—

The Chair (Mr. Peter Z. Milczyn): Please sit down.

Dr. Betty-Anne Story: I'm a family doctor in Brantford and I've been working there since 2005.

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Before I come to the final thoughts I have for you, I want to give a little background as to why I wanted to have this opportunity to talk to you today, because I appreciate very much being able to speak to you.

First of all, medicine is my second career. I've already had a career. Previously, I was an organic chemistry lab instructor.

When I was an undergraduate, I refused to consider medicine as a career option for myself because I was too afraid that I would accidentally kill one of my patients. I avoided medicine for that reason.

I was teaching the undergraduate organic chemistry lab's pre-medical students, and they challenged me: "Why don't you consider medicine?" I thought, "Well,

why don't I? I could take responsibility and look after people appropriately."

So I went into medicine. I chose family medicine. When I graduated, I took the Hippocratic oath, and then a few years later, I took the Hippocratic oath again.

I've decided to try to treat my patients as whole patients, not just trying to do band-aid solutions. I want to find out what's going on with my patients so that I get to the root of the problem. I have quite a variety of patients, with different backgrounds and different beliefs.

As you know, last year, Bill C-14 allowed for assisted death to be permitted under certain circumstances. It allowed for the rights of the patients and the physicians to be balanced, with the provinces and colleges to work out the details. You're probably aware, from all the speakers today, that the CPSO policy says that either you perform the procedure or you must provide an effective referral, or you face disciplinary action that could be a reprimand or up to losing your licence. The care coordination program, started up through the ministry, is only by physician referral.

So I'm in a really torn situation here. I don't know what to do. I thought I'd like to look at my colleagues in Brantford and get a brief snapshot of what they're thinking also. March 21, I did a short survey; that was two days ago. I sent something to as many different doctors' offices as I could in Brantford, to see if any other people had these conscience concerns and whether an effective referral would be an issue for them.

I got 14 responses, which isn't great, out of about 70 family doctors and over 100 other doctors. Ten supported conscience protection; one said no; three didn't know. Six felt a lack of conscience protection would affect their practice. Eight thought patients should be permitted to have direct access, without a referral. This is out of 14 doctors, which isn't a big sample.

In my own practice, I have one patient who has said, "I am in favour of assisted death, but I don't want you to be forced to do this against your conscience."

For me, it's a dreadful dilemma. I don't know what to do, because I'm doing the very best I know for my patients, and I really care for them. They know I care for them, and I take the time for them. My choice is, either I can refer for assisted death, if a person requests that, but then I can't live with myself, with my medical training and my background; or I don't refer and I get disciplinary action; or I choose to move to a different province, a different country, where I can practise without concern for my conscience. But then I abandon my patients that I care for and who want me as their doctor. It's a dreadful situation right now, so that's why I've come to the committee.

I would like it if there is some way that you can balance my patients' needs for access to assisted death, if they want it, and my need not to be forced to refer against my conscience. What I'm asking is that you amend Bill 84 to allow for conscience protection for health care workers and protection from discrimination, which is in line with other jurisdictions, and that you allow patients

direct access to this care coordination service without a physician referral.

If you want to know who has issues with assisted death, from the conscience point of view, do you ask those who are promoting assisted death or those who have the conscientious objections? I'm here to present my view that you can balance the rights of the patients and the rights of the doctors, if you protect conscience rights and if you allow patients direct access.

That's all that I would have to say.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor. Mr. Fraser, you have three minutes.

Mr. John Fraser: Thank you very much for presenting today and for speaking about that balance. As you're a practitioner—you may have been here earlier on—the decision to provide medical assistance in dying, or to legalize medical assistance in dying, is really essentially about choice. In order to have choice, you have to have access to palliative care.

So as a practitioner, what are your pathways for referral?

Dr. Betty-Anne Story: Right now, for referring for assisted death, I would have to phone the care coordination service that's set up, to find out who I actually send someone to. But I can't do that, from the conscientious point of view—

Mr. John Fraser: Oh, no, pardon me. I probably didn't make myself clear. For someone who needs palliation, what do you do right now?

Dr. Betty-Anne Story: Oh, for palliation. We have a wonderful palliative care team in Brantford. It's just a phone call to the CCAC or to one of the palliative care doctors.

Mr. John Fraser: Stedman, and palliative care docs. Okay. The reason that I ask that question is that I think that's a critical piece in this. As I said earlier, we all agree that this is about compassion, mercy and love, and access to those services is important.

So the care coordination service: I think that it's a critical piece, to be something that's patient-facing and that will promote access. What is your view on that?

Dr. Betty-Anne Story: I think a care coordination service is an excellent idea as long as the patient also has direct access to it, because not everybody in the province has a family doctor, and not everyone would have access without a family doctor.

If you insist that a physician must do the referral, or you get a physician like me who can't do the referral, how does the patient get access if they can't make direct access themselves?

Mr. John Fraser: I agree with you. I think that's one of those critical pieces, because one of the things we want to make sure of is that people have access to all the services that are available to them. There are people who sometimes want to find out information without sharing that with their practitioner, their family or anybody who knows them.

Dr. Betty-Anne Story: Yes.

Mr. John Fraser: I want to thank you again very much for your presentation and for the work that you do.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you very much for being here, Doctor. I do have to start off by saying that organic chemistry was my nemesis in year 2 of pharmacy. It almost changed my career goals at the end of the year, but I managed to get through it, so I have a lot of respect that someone not only did well in organic chemistry but facilitated the teaching of organic chemistry.

I do just want to ask for your comment; I asked the previous presenter this. It's one thing to have the self-referral patient process set up, but unless you guarantee or protect the conscience rights, you're still going to have the same problem going forward, even if the government does create the system that we want them to create. Is that right?

Dr. Betty-Anne Story: Yes. You have to protect the conscience of the doctor as well.

Mr. Jeff Yurek: They're intertwined.

Dr. Betty-Anne Story: They're intertwined. Bill C-14 does say that we're to balance the patients' rights and the doctors' conscience rights, so there has to be a balance somewhere.

Mr. Jeff Yurek: I've also noted that it has come up numerous times in different discussions about palliative care. We're talking about medical assistance in dying here. I think palliative care is another whole different topic, and I wish we had this enthusiasm across the province to ensure that we had palliative care throughout the province, because I know it's scant in certain areas.

I think we really need to work on that option for people who have terminal diseases or are at the end of their lifetime. We really do need to get on-board with palliative care support throughout the province. I just wanted to throw that out there.

Dr. Betty-Anne Story: It's crucial; I agree 100%. It's crucial that we have good palliative care.

Mr. Jeff Yurek: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Thank you so much for coming, Dr. Story. It was very interesting, listening to you. I'll ask you a personal question, but it's not because you're sitting there that you have to answer. You have a right to say no.

In your practice, have you ever had a patient ask you to help them end their suffering and their life?

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Dr. Betty-Anne Story: Let's say about six or eight years ago, I had a patient who said, "I don't want to keep living. Let me go." There was a very simple procedure that would have made them so that they were fine. They were very depressed too at the time because of their medical situation.

When we worked with it and talked about it, eventually they decided that they would go for the procedure and they weren't going to die. Just a couple of years ago—

this is an older patient—I got to see the patient, and they were so proud of showing me a picture of, I think, their great-great-great—it was a lot of different number of "greats"—grandchild whom, had they gone through and died or been killed at the time when they wanted to, they would never have seen. They were just so proud of that great-great-great—I don't know how many "greats"—grandchild.

M^{me} France Gélinas: I tip my hat to you that you took the time to connect with your colleagues and ask them before coming here. Aside from this, were you ever asked by the government to help shape—did you ever have an opportunity to be heard, to have a safe place to have those dialogues, put forward by the Ministry of Health, before this bill came forward?

Dr. Betty-Anne Story: I have put out my thoughts to the College of Physicians and Surgeons. Whatever surveys were available through the government, I did all of those surveys. I've been trying to make my views known ever since I knew that anyone would listen to my views.

M^{me} France Gélinas: Do you feel like you've been listened to?

Dr. Betty-Anne Story: Most of the time, no.

M^{me} France Gélinas: All right. Thanks for your honesty.

You participated with online questionnaires—that's what you're talking about?

Dr. Betty-Anne Story: Yes, I've done those. I've written letters. I've written my own emails. I've met with my member of provincial Parliament. I've met with my MP. I've met with anybody who would listen to me.

M^{me} France Gélinas: Very good. Thank you for your effort. When you reached out to all of your colleagues and 14 of them got back to you, do you know if any of them had had experience with medical aid in dying since the law changed?

Dr. Betty-Anne Story: I don't know. I didn't ask that. It was just a very short, simple survey.

Apart from the survey, I do know one colleague who was approached by a patient to ask, "What are my options with assisted death?" The colleague wasn't quite sure what the answers were so they had to do some research into it and then told a group of us doctors that this had happened, and what-would-we-do sort of thing.

M^{me} France Gélinas: Did it work out well? I take it he phoned the 1-800 number and—

Dr. Betty-Anne Story: I don't actually know what the doctor did in the end, but I don't think the patient went through and finally did an actual request.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Dr. Story, thank you very much for coming this afternoon. If you'd like to provide us with something in writing, you can do so until 6 p.m. next Thursday, March 30.

Dr. Betty-Anne Story: Okay. Thank you.

DR. JOHN SCOTT

The Chair (Mr. Peter Z. Milczyn): Our next witness is John Scott. Good afternoon, sir.

Dr. John Scott: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation. Your round of questions will begin with the official opposition. If you could please state your name for the official record as you begin.

Dr. John Scott: My name is John Scott. I'm a palliative care physician in Ottawa, working in a hospital setting. I participate in the care of approximately 600 patients per year who would have advanced disease and be facing death in the foreseeable future. I have been involved in palliative care since 1975, when I was involved at the beginning of the first palliative care unit in Canada—in the world, actually—in Montreal.

Over the last year, I have had 10 patients who have requested medical aid in dying, although I've had a much longer experience of many patients who will be wanting to talk to me about death, about fears, about wanting to die. It's a very long, complex and nuanced area. But in terms of my actual MAID experience—10 requests.

I've certainly seen amazing advances in the field of palliative medicine, and I am very grateful that now I have tools to control pain, nausea and shortness of breath. It is an amazing group of people to be working with. I very much am fulfilled by my job. Like you, I have seen the increasing aging of our population and therefore rapid increase in the need for palliative care. I am now worried that I will not be able to continue my work in palliative care because of the lack of conscience protection in Ontario.

In common with many other physicians to whom we have listened today, I consider a formal referral to MAID to be a participation in a procedure that will harm my patient. I think a lot of people do not recognize what a referral is for a physician. It's not just giving an idea or sending a little note. If I sent a referral to a MAID physician, in order for them to bill OHIP they have to put my name and my billing number on their invoice. I become part of that whole situation. I become registered in a way that I consider inappropriate for my views on this subject.

I want to continue to care for my patients, and, like others, I am requesting that as legislators you protect me from being forced to participate in MAID in a way that is against my conscience, and protect me from discrimination of any kind because of my stand.

I wanted to address how I believe the lack of conscience protection will impact palliative care in Ontario. In my opinion, this lack of protection and the imposition of mandatory referral will decrease patient access to palliative care by decreasing the number of physicians available.

In February 2015, three quarters of all palliative care physicians in Canada were polled as being opposed to involvement in hastened death. Yes, since then we have come to accept that this is law and a legal option for our patients, but the lack of conscience protection has caused

anxiety in palliative care physicians in Ontario. The looming threat of discipline for following one's conscience is discouraging the recruitment of new palliative care physicians and causing experienced ones like me to consider a shift in career.

The Canadian Society of Palliative Care Physicians has stated that mandatory referral to MAID is not necessary to ensure access and it causes unnecessary harm to palliative care physicians. It's my opinion that forcing physicians to refer for MAID will keep physicians away from the practice of palliative medicine at the very time when our aging population demands that we should probably double the number of palliative care physicians in Ontario. Access to palliative care is a serious problem. Protecting the conscience rights of palliative care physicians will improve palliative care access.

We have heard concerns that patients in advanced stages of illness will be too sick and too vulnerable to access MAID, and that is why compulsory physician referral is needed. This is not the reality that I see at the bedside. The majority of patients who want to explore MAID are at an earlier point in their illness, when direct access is possible, often with the support of family and friends. It's extremely rare that such requests first arise when a patient is bedridden with severe symptoms that prevent active involvement. In fact, most want to be in charge of the process.

In the hospital in which I work, a process has developed that in many ways mimics the Alberta access system that we've been discussing. In our hospital, anyone in the circle of care can activate the MAID process: patient, family, nurse, social worker or doctor. Physician referral is not required to start it. If a patient is expressing a wish to explore MAID, anyone can ask the MAID team for the hospital to come to see the patient, provide information, and explain how to complete the request form. Once signed, the assessments are activated. So here at this local level, we have made it work. We have made access much easier for patients, but at the same time have avoided conflict over conscience by not requiring physician referral. I am able to continue controlling symptoms as their palliative care physician throughout this process because of this.

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However, the threat of college discipline is still looming. We fear that this co-operative approach will be disallowed and that physicians like me will be disciplined.

So, yes, we need an open, flexible access system, like that in Alberta, but first and foremost we need robust conscience protection to be added to Bill 84 so that palliative care patients will continue to get the care they need.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor.

Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you, Doctor, for coming in. It's interesting that, within your own facility, you created a system that worked. However, that wouldn't work

outside for the average family doctor—just because it's such a wide open world—where some sort of patient self-referral system could be developed with—

Dr. John Scott: Exactly. Yes.

Mr. Jeff Yurek: But we still need to deal with the effective referral regarding medical assistance in dying.

Dr. John Scott: I bring it up almost as an example that, if we could get together, we can come up with the kind of accommodations so that we can have conscience protection and good access to MAID for those who want it. There seems to be this obstruction to looking at creative ways. Right now, we desperately need the protection that only you can give us.

Mr. Jeff Yurek: I think it's incumbent on the government to reach out to the front-line health care workers to find this solution and implement it. But you're right: Our job would be to help protect your conscience rights.

I've heard the College of Physicians and Surgeons say that effective referral doesn't necessarily implicate you with the referral; however, I heard earlier today that if there are certain referrals that you did make that were a bad error, you would be held liable for certain referrals that you made. To me, it seems opposite to what they're saying. You either are liable for your referrals or you're not—or part of the process. Can you talk about that? Hopefully I was clear with what I just described.

Dr. John Scott: My own take—I'm not part of the college process other than that I have to be licensed by them. I agree that there is definitely some confusion as you read the literature on that. I think people do not—I can see why someone, at a glance, might say, "Well, as long as you don't have to actually inject the patient, what does it matter that you refer? It's not a big deal." But, if they understand what the concept of a physician referral is, in that you are actually making a recommendation—you never send a patient to another physician without it being viewed as a recommendation. It is embedded in us as physicians that we don't—and as I said, even the reimbursement process confirms that. The only justification for paying this consultant is that a primary care physician has actually made this referral.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you. Madame Gélinas, you have three minutes.

M^{me} France Gélinas: I seem to be asking personal questions. Same—because you're sitting there, it doesn't mean that you have to answer them if you're not comfortable.

You've told us that a hospital in Ontario where you practise has found a middle ground that gives access to, I guess, at least the 10 requests that you have dealt with since the law changed. I'm sort of curious, and if my curiosity bothers you, you can say no: How did that affect the relationship between the physicians who are on the MAID team versus the physicians who oppose referral? How did that work itself out?

Dr. John Scott: Well, I think it actually lowered the tension. In a way, the dialogue was much more available. In fact, the MAID team openly says they count on me

being the one who presents the alternative to a patient. They want to be sure that the palliative care options have been fully explored and that the patient has had lots of opportunity to look at other things. So they're not looking for referral from me. In fact, even my colleagues who support MAID in their political views would not be involved in MAID referrals or in MAID assessments.

I think the actual separation of palliative care from the MAID process is very important for the safety of the patient, and it seems to work. I think we could, in a combination of an access centre, a care coordination system and transfer of care, if necessary, in very rare situations—that combination could provide the same type of thing that I'm experiencing in my hospital.

M^{me} France Gélinas: So there was not this big division as to—I sort of assume that there are also palliative care physicians, but I may be wrong in that assumption. Who are the people on the MAID teams?

Dr. John Scott: There will be very, very few palliative care physicians in the whole country who will be involved in actually either assessing or in delivering the MAID procedure. Anesthesiologists are very commonly involved because of the complexity of drug—in our hospital, only physician-administered MAID is offered, not patient-administered, and that's a trend that's happening. And then another specialist, often a general internal medicine specialist, has been involved. But it would depend, obviously; in various hospitals, different types.

But, no—a lot of people, of course, assume that palliative care is somehow involved and, as a result, patients are afraid to see me. "Oh, are you the one that gives the needle?" It has actually been very difficult—talking about stress on caregivers, it has been very stressful for palliative care doctors.

M^{me} France Gélinas: Do you feel that the model that you have in your hospital could be replicated in other hospitals in our province?

Dr. John Scott: I believe so, but knowing that the community needs to have equal access, I do think an overall coordinated system for the whole province is the best way to go, with a view that, then, they might access the local hospital MAID team and it could be both. Patients could do it within the hospital or they could do it through a provincial process. I think that flexibility and openness and avoidance of conflict over conscience can be achieved.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser has three minutes.

Mr. John Fraser: Thank you very much for being here today, Dr. Scott, and thank you for your work.

I don't think we've had an opportunity to meet. I met with a lot of your colleagues in Ottawa, and I know the work that you do and I know that palliative care is a critical part of this process. I also know the work that has been done at the Ottawa Hospital to create that environment where it works, and appreciate that the community, the circle of care, in the Ottawa Hospital figured out a way to work together, which I think is critical.

We're all here struggling with the balance. The thing that I do know is that palliative care needs to be there. I'm glad you pointed out the risk of the two things being conflated, because they are different. We've made a lot of efforts in the last—we did a series of consultations to keep those things separate.

When you talked about the community, in terms of—you've made it work in the hospital, which I think can be replicated as long as you get the buy-in of the circle of care community that's there. From a community perspective, how do you reconcile—you talked about the care coordination service. How do you reconcile those things from the perspective of a family doc in Fordwich?

Dr. John Scott: I think it's why we need a provincial level of coordination, because there are going to be so many different aspects. I'm in a 1,000-bed hospital, so obviously, that's a very different setting than an individual in a smaller community, but I think Alberta has exactly the same thing. Their coordination system is dealing with a rural population as well.

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I have palliative care colleagues in Alberta that I've worked with quite a bit. They were really early on involved in the process of creating that system. Not only do people access MAID better that way, but they also access palliative care, the ones who are having difficulty. It actually helps both systems very well.

Mr. John Fraser: If you weren't here earlier—there is a commitment to develop the care coordination service, and I think that's a critical piece as we go forward, because it's—am I running out of time?

The Chair (Mr. Peter Z. Milczyn): Thirty seconds.

Mr. John Fraser: Thirty seconds. Okay. It's critical that everybody is on deck and able to provide the care that they can, because they want to continue to care for their patients.

The physicians that I've met with in my office have expressed exactly the same thing that you're expressing to me today: You want to make sure that you provide those palliative services to people who are suffering.

I want to thank you again for your presentation today.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Scott, for coming in this afternoon. If you want to submit something in writing, you may do so until 6 p.m. next Thursday, March 30. Thank you.

MS. HELEN MCGEE

The Chair (Mr. Peter Z. Milczyn): Our next witness is Helen McGee. Good afternoon.

Ms. Helen McGee: Hello.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation. Your round of questions will begin with the New Democratic caucus. If you could please state your name for the official record, as you begin.

Ms. Helen McGee: Helen McGee. Thank you for the invitation to present my concerns and recommendations regarding Bill 84.

My chief concern is that health care professionals who object to referring patients for medically induced death are not protected in the bill. I do not accept the assumption that patient access to this procedure requires conscientious objectors to refer, if a care coordination service is in place. Ontario patients access timely treatments without referral for substance use, smoking and the early phases of psychosis. In addition, care coordination services provide access to a wide range of health services, including medically induced death, in other provinces.

My recommendation is that you amend Bill 84 to provide protection for conscientious objectors. If the bill is passed, a conscience amendment will restrain the bodies that employ, regulate or represent health professionals in Ontario from disciplining conscientious objectors who cannot provide, or refer patients for, medically induced death.

Conscientious objection to medically induced death is not simply squeamishness, nor is it a choice opposed to the patient's choice. It is based on the health professional's perception of the right of the human person to be loved, not discarded. This conviction of the dignity and value of the human person may or may not be deeply connected to the professional's spiritual life.

I am a psychiatric nurse and clinical leader who has worked with people affected by schizophrenia for more than 40 years. I currently work with mental health teams to improve the quality and safety of patient care. I regret that my patients can legally access medically induced death, especially since Ontario does not provide sufficient services to relieve suffering in the context of terminal or chronic illness.

People with mental illness currently qualify for this ethically controversial procedure if they also have a medical illness, are in an advanced state of irreversible decline and meet the other eligibility criteria. However, psychiatrists, lawyers and ethicists are hard at work justifying expanded criteria so that mental illness as the sole underlying condition will qualify them for medically induced death if they request it. These trends will definitely affect my patients.

My patients recovered from episodes of psychosis that involved intense fear and isolation related to hallucinations and delusions. A number of them experienced depression during the recovery process, and suicide prevention was critical. Some of my patients attempted, and others completed, suicide. Survivors reflected on the reasons that they lived during their conversations with me. Then, we had more time to work together to find meaningful relationships and activities in the context of chronic illness and disability. This took time.

Mandatory referral eliminates the potential of the therapeutic relationship for people who request medically induced death. I'm also concerned that the obligation to present it as an option abuses my power in the therapeutic relationship, and implies that I endorse it as a viable option. It really acknowledges to the patient, "Your life is not worth living."

As the American Nurses Association explains, participation in this procedure violates my professional role integrity. It does not promote health. In addition, I'm concerned that even one medically induced death among my patients will affect the entire community of patients, many of whom share the same psychiatrists, attend group sessions together and even live together in boarding homes.

I want to state here that I emphatically do not support the Registered Nurses' Association of Ontario's position that "practitioners who opt out still have a duty to refer those seeking assistance in dying to another professional." Let me speak for myself as a conscientious objector: Referral constitutes participation in medically induced death. Instead of making a referral, I want to care for patients and relieve their suffering.

For the sake of safety and health care, our patients and family members need professionals who think critically about state-mandated services that are ethically controversial. Here's an example: Conscientious objectors could have enhanced patient safety in Quebec emergency rooms when people brought handwritten "Do not resuscitate" notes after they had taken lethal overdoses. Emergency department doctors failed to provide antidotes for them. The ethics officer of the Quebec body that regulates physicians noted that the doctors were "confused" about their ethical obligation to provide emergency treatment. If we eliminate from health care the professionals who have the courage to question the ethics of state-mandated services, patients are not safe.

The Chair (Mr. Peter Z. Milczyn): Thank you. Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Thank you so much. I don't know how long you have been here, but we went through the criteria to qualify for MAID. The way they are written now, are you comfortable that we have hit the right balance, or do you think that some of the patients who you work with are still vulnerable?

Ms. Helen McGee: All of the patients I work with are vulnerable and I'm opposed to medically induced death, so I'm not satisfied with the law, but I have to live with it. I know that there are people who are anxious to provide medically induced death for as many psychiatric patients as possible—

M^{me} France Gélinas: Who would those be?

Ms. Helen McGee: Ethicists, lawyers, some psychiatrists—they're writing about it in the professional literature. They're talking about it in professional conferences.

M^{me} France Gélinas: Wow. That's the first time I've heard that. This is really hard to swallow.

The law is there, so it is a legal procedure. The ship has sailed. Now we have the criteria that says, "Here are the criteria that you have to meet to be eligible for MAID." Are you comfortable commenting on that part of it, given that it is the law?

Ms. Helen McGee: I guess I'm thinking both of the current situation and the future implications of the trends for my patients. Currently, my patients who have cancer

and also schizophrenia are at risk for medically induced death if they go to a facility that provides it. There are some palliative care services in Toronto that do not provide medically assisted death, and others that do.

M^{me} France Gélinas: You think they're at risk because of discrimination because they have a mental illness? Is this what you're saying?

Ms. Helen McGee: No, but I think people are vulnerable to depression when they have either chronic or terminal illness. When they're depressed, they sometimes say, "I want this to be over," or their team suggests medically induced death as an option. As I said, in the therapeutic relationship, you have to be very careful about trying to equalize the power, but if I as a professional say, "Here's an option," it's implying that I consider this a fair option for this person—almost a recommendation, although they're free to say no.

M^{me} France Gélinas: So what you're saying is that professionals are not waiting for clients to ask for it, but are offering it as a range-of-treatment plan?

Ms. Helen McGee: Well, this is anecdotal because there is no transparency; there's no data, except numbers, for medically induced death. But anecdotally, I do hear that people are being offered a menu of options that includes medical assistance in dying.

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The Chair (Mr. Peter Z. Milczyn): Thank you. We'll switch to Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for your presentation. There were a couple of things that you brought up in terms of what's next, so I can understand the concerns there. There will be some very serious public debate around that. There is also, through some of the work I've been fortunate enough to do inside government—there's a bit of a lack of understanding in the community about consent and what that actually means in Ontario. I'm glad you brought those up. I think those are things that, as we go forward with this, we have to make are very clearly understood by people.

We talked about palliative care pathways. As a practitioner, do you have a pathway for palliative care? How would you refer?

Ms. Helen McGee: No, we're developing integrated care pathways at my hospital but, because we work with people with only psychiatric illness and addictions, we don't have a care pathway for palliative care.

Mr. John Fraser: Yes, so you don't have it? So there's not really any complex—people with dual diagnoses or with a complex medical condition, being physical and psychological. That's why I asked you. I thought—

Ms. Helen McGee: Right.

Mr. John Fraser: But you are developing integrated pathways? Again, going back, I think that's a critical piece in the services that are offered for people. In order to have choice, you need choices.

In terms of access for patients, there have been conversations in and around a care coordination model. Do you have any comments on that?

Ms. Helen McGee: I think if the care coordination model includes a range of services, not only medically assisted death, I would feel comfortable referring to a care coordination service or supplying the number to someone.

Mr. John Fraser: I agree. I think that has to be part of any care coordination.

Ms. Helen McGee: If it were specific regarding medically induced death, I could not give that number.

Mr. John Fraser: Or whether it's a coordination care service that exists broadly in the community or a care coordination service as described by Dr. Scott here earlier, which is that it's out there as an option, it's critical.

Ms. Helen McGee: That sounds like it could work in other places.

Mr. John Fraser: How much time do I have?

The Chair (Mr. Peter Z. Milczyn): One minute.

Mr. John Fraser: One minute? Actually, I'm fine. Thank you very much for being here today and for presenting.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you for being here. A question with regard to your other co-workers, your other RNs that you work with and such: Are they in line with RNAO's position?

Ms. Helen McGee: I don't really freely talk about this at my workplace and I don't identify my workplace here. I'm speaking as an individual. A number of my colleagues have left the Registered Nurses' Association of Ontario over this issue, and also the Canadian Nurses Association, so really, we're political and professional orphans on this issue. That's why I quoted the American Nurses Association; I think they have a multi-dimensional, multi-layered approach to this ethical issue. They say that assisted suicide, euthanasia and medical assistance in dying affect not only the patient but the professional—the nurse—and the community in that the trust is eroded in the health care professional. The community doesn't trust people anymore, as Dr. Scott was talking about. Palliative care, patients' and families' concerns about palliative care: All of those are affected. It's a kind of three-layered impact of the legalization of euthanasia and assisted suicide.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much, Ms. McGee. If you wish to provide us with something in writing, you can do so until 6 p.m. next Thursday, March 30.

OFFICE OF THE INFORMATION AND PRIVACY COMMISSIONER OF ONTARIO

The Chair (Mr. Peter Z. Milczyn): Our next witness is the Office of the Information and Privacy Commissioner of Ontario. Good afternoon, sir. You have six minutes for your presentation. If you could please state your name for the official record as you begin.

Mr. Brian Beamish: Good afternoon, everybody. I'm Brian Beamish. I'm the Information and Privacy Commissioner for the province. Thank you for the opportunity to meet with you and provide some comments on Bill 84.

As you know, my office is responsible for the oversight of the province's access-to-information laws and the province's privacy laws. I'm here to speak about a very specific and narrow issue in Bill 84 related to the access-to-information side of my responsibilities, but an issue that I think unnecessarily detracts from the public's right to know—a very important principle supporting our legislation. Bill 84, as it's currently written, would amend our provincial Freedom of Information and Protection of Privacy Act and its municipal counterpart to exclude information that would identify a facility providing medical assistance in dying. In other words, an individual in the province would not be able to put in a freedom of information request and receive any information that would identify a facility. That could be a fact as basic as that facility is providing those services, the number of medically assisted deaths being performed at that facility or what have you. That type of information, generally, is accessible to citizens in the province. We have a publicly funded health system, and it's important that people be able to understand how health dollars are being spent and how our system is operating. So I am recommending a very simple, straightforward amendment that would remove that exclusion from the act.

As context, we would also be very skeptical of these kinds of carve-outs from our access-to-information regimes. The act currently strikes a balance between the public's right to know—a very important right—and what are acceptable exclusions or exemptions from that right. I think it does that in a good way, and that is the work that our office deals with on a daily basis. These types of carve-outs, to me, are blunt instruments. Inevitably, they leave a gap in the legislation, they lead to unintended consequences and they act to hinder transparency and accountability.

Maybe I can give you just a quick example of how they can be problematic. When the freedom-of-information act was expanded to include hospitals within their ambit, there was a carve-out for records relating to the provision of abortion services. We were told at the time that that was because of the potential risk of threats to providers of abortion services and to facilities where abortions were performed. Subsequent to that, the Ministry of Health received a freedom of information request for province-wide statistics on how many of these abortions were being performed and how much money was being spent on it. That carve-out was relied on to deny access to that basic information. So when I express a concern about carve-outs, it's for good reason. It's not theoretical; it's real.

When we approach these types of exemptions, we ask, really, two questions. One: Is there a basis for it? Is it backed up by evidence that there is a need for the

exemption? Two: Are the current provisions of the act not sufficient?

In terms of that first question, my office and I have not been able to see any reason why the identities of facilities providing these services need to be hidden. We have looked at jurisdictions where there has been medically assisted death for many years now—Switzerland, the Netherlands and Belgium, for example. Not only is it easy to identify the facilities where the services are available, but there's no evidence that those facilities have ever been subject to threats or to any kind of violence at all.

We have also sat down with staff at the Ministry of Health. I personally have met with Ministry of Health staff and asked what evidence they have to justify the exclusion of the identity of facilities. Do they have evidence of threats of violence here in Ontario that would justify not disclosing where these services are available?

I would say the best justification was that the opponents of medical assistance in dying may use aggressive tactics to express their criticism, and to me that is not acceptable. It's far too vague and hypothetical to support a carve-out and an exemption from the people's right to access information.

What makes this even harder to understand is, as the act is written now, it currently provides a provision that allows for the non-disclosure of information where the security of a facility is at risk. I would point you to section 14 of the provincial act, and there's a similar provision in the municipal act, but 14(1)(i) says that "A head"—that could be the Minister of Health or the head of a hospital—"may refuse to disclose a record where the disclosure could reasonably be expected to ... endanger the security of a building...."

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I would suggest that where there is a significant and real threat to a specific facility, the act covers that, but there's no evidence that there needs to be a blanket exclusion to the whole class of facilities that are providing medical assistance in dying.

I can sum up: We take the right to access to information very seriously. Any exclusions need to be justified. In this case, we see no justification, and we see that the current act provides for any exceptional circumstances.

The Chair (Mr. Peter Z. Milczyn): Thank you, Mr. Beamish. We'll start this round of questions with the government side. Mr. Fraser?

Mr. John Fraser: Thank you very much, Mr. Beamish, for being here, and for your presentation and for your work on transparency and accountability.

As far as protection of privacy for individual practitioners, what is your position?

Mr. Brian Beamish: You will know that the act currently also excludes information that would identify a service provider. I don't want to quibble on terminology. I wouldn't call that a privacy provision, because we would consider that their professional information and not subject to any privacy protections.

That's a hard question. We did consider whether that exclusion was justified or not, but at the end of the day, I think we were satisfied that there was no particular public interest in disclosing the names of the service providers themselves.

Mr. John Fraser: When we traditionally think of these services, we think of them as being hospitals, but in this case, they may be other facilities as well. Hospices are largely community-based and have community boards, and, quite frankly, are perhaps more at risk. But maybe more importantly, they're struggling with how they're going to deal with this and come through it in a way that is compassionate with regard to their ethos and the foundation on which they've built themselves.

When I think of this policy, I don't see it inside the hospital paradigm. I would just ask you to consider that when you look at it. I get what you're saying, and I don't totally disagree with it, but I think we have to consider that.

Again, I talked earlier this morning about the proximity, and how we're trying to work through this thing, and there may be some validity in looking at that. That's all I ask.

Mr. Brian Beamish: I think that's a fair point, that facilities may cover a broad spectrum of locations.

Again, I go back to the need for evidence to support a risk. If the Ministry of Health had been able to come to us and say, "Here's a risk we see," or if we had seen that elsewhere—I'm not suggesting that we necessarily had to have it from the ministry. But if we had seen that there was a risk, even to a hospice, that their security would somehow be threatened, then we would have considered a different approach to this. But that has just not been our experience.

Mr. John Fraser: What I'm asking, as the second part, is this: I think that we have to look at that part as to where we're at, where we're coming from, and how people are dealing with this, in a way that will help us come through it together. That's all I ask.

Thank you very much.

Mr. Brian Beamish: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thanks very much for being here today. You brought different thoughts to the situation, with the fact that you researched it.

Just to throw this out: Have you looked at other jurisdictions where access to which facilities were not performing medical assistance in dying—were there any situations where those facilities were harassed in the same way? That was the concern.

Mr. Brian Beamish: Sorry. Facilities that were not providing it and received harassment because of that?

Mr. Jeff Yurek: Yes.

Mr. Brian Beamish: I'll be honest: We did not look at what you're suggesting, which is the reverse, but that's an interesting angle.

I think the threat that had been suggested to us was more the fact that by identifying a facility—which is how

this is written. Anything that would identify a facility performing it was excluded, the threat being that those facilities might be subject to some type of violence or harassment.

Mr. Jeff Yurek: Okay. It was just all I thought about this. If you do in the short term, could you submit it to committee?

Mr. Brian Beamish: Absolutely.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas.

M^{me} France Gélinas: Well, as a very heavy user of freedom of access to information, as well as a very heavy user of review of denial of freedom of access to information—

Mr. Brian Beamish: That happens?

M^{me} France Gélinas: Oh, yes. I have my 25-buck cheques lined up.

So I'm all in favour of this. I take it that, since the bill has been tabled and all of this, you've had an opportunity to talk to the Ministry of Health. Are they open to what you're bringing forward?

Mr. Brian Beamish: I don't want to speak for the ministry. I can say that we made our views known prior to the introduction of the bill and after the introduction of the bill.

M^{me} France Gélinas: Okay. So you've done your best and now you're leaving it to us.

Mr. Brian Beamish: That's why I'm here today.

M^{me} France Gélinas: Okay. We very much appreciate that. I fully support that.

In the laws right now, the way they are written, if there was an inkling of maybe a threat, they would have full rights to deny the freedom of access to information—and believe me, they do. They know all of the reasons why they are allowed to deny, and they use them all fully.

I have no doubts that every hospital in Ontario knows full well that, if they feel it is a threat to them, they're not going to share that information. They will be covered by the freedom-of-access-to-information laws, and all will be good and safe.

I agree with you. I don't understand why we're clawing this back. I don't understand why we're going to create this gap. We already have safeguards in place, and the hospitals use them fully. Thank you.

Mr. Brian Beamish: I think my submission has been circulated. I neglected to say that, at the very back, there is a suggested amendment to the bill.

The Chair (Mr. Peter Z. Milczyn): Thank you. If there is anything further that you would like to submit, you have until 6 p.m. next Thursday, March 30.

Mr. Brian Beamish: Okay. Thank you very much for the opportunity.

The Chair (Mr. Peter Z. Milczyn): Thank you, sir.

DR. MARIA WOLFS

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Maria Wolfs. You have six minutes for your

presentation. If you could start off by stating your name for the official record.

Dr. Maria Wolfs: Okay. My name is Maria Wolfs. I'm an academic endocrinologist practising in an academic centre in Toronto.

Mr. Milczyn, thank you for the opportunity to present to your committee on the topic of Bill 84. I wish to specifically address the importance of including conscience protection into Bill 84 for physicians opposed to medical aid in dying. This is necessary because Ontario has the only college of physicians in Canada that requires effective referral for procedures to which a physician has conscientious objection.

I specifically want to address my concerns as a medical educator. I'm involved in the education of medical students and residents, and I fear that if conscience protection is not included in Bill 84, future physician training in Ontario may be at risk.

Currently, the University of Toronto, the largest medical school in Canada, has ethics guidelines that fully support a medical trainee's right to refuse participation in activities for ethical reasons without any repercussion. Unless conscience protection for physicians is set in law, this policy is vulnerable, just as the ethical protection for physicians was revoked by the Ontario college of physicians in a heavy-handed way. Without such protection, medical students are at risk for bullying and intimidation.

Also, how can we train students under ethical protection, and then refuse it to them when they are no longer in training? And what happens to a medical student or resident's moral integrity when they see their teachers and mentors forced to act against their own ethical values, or risk being penalized by the college because they won't?

I work in an inner-city hospital that serves the needs of under-housed, displaced, mentally ill, cognitively impaired, educationally disparate and vulnerable patients. I have chosen to work in this environment because I want to serve in a fundamental way. I see this same call and desire to serve in the many medical students and residents who I work with on a daily basis. Do we want to create a medical environment where their compassion, integrity and desire to serve are eroded through an assault on their ethical integrity?

1600

You may ask, how would a lack of conscience protection erode ethical integrity? To start off with, let me please stress that acting in accordance to one's conscience is not just following an opinion or a personal feeling. Conscience is an innate human faculty, universal, and recognizes the core of a person's freedom and integrity.

To force a person to act against their conscience in any circumstance is to destroy their core and fundamental integrity. Freedom of conscience is therefore fundamental to the freedom of an individual and must be protected as an innate human right.

A patient's request for euthanasia cannot override the moral harm that referral for such a procedure would

cause to the physician. Such a referral is akin to co-operating with an act that a physician has found morally offensive, and acting in that way will inevitably erode her moral integrity. Effectively, a moral lie enters into the patient-physician relationship, which should be characterized by truth and trust. We would be hard-pressed to find patients who want their treating physicians to act without moral integrity, but that is exactly what requiring an effective referral is forcing them to do.

Let me ask you, do you want your physician to act at all times with moral integrity? If the answer is yes, you cannot possibly demand that she perform an objectionable service that is requested by a patient, which will irrevocably damage and violate her moral character forever. Patients should have access to such services directly without requiring a referral from an objecting physician.

Let's be honest. Not everybody in Ontario supports euthanasia. It's a contentious issue, and while fully legal, it is not universally morally acceptable to everyone in Ontario. In our pluralistic and multicultural society, there should be room to support both a patient's and a physician's right to follow their conscience.

As the diversity of our patients in Ontario increases, so should the diversity of the physicians and those being trained. This ensures that everybody in Ontario can receive the best and most culturally sensitive care. Even medical school admission policies are being revised to increase the diversity of their applicants, and the medical school admissions committees are being diversified to ensure that. In order to ensure this diversity, we must be equally respectful and open to the personal values and beliefs of both patients and physicians.

In conclusion, Bill 84 must include conscience protections for doctors opposed to MAID and not force them to refer for MAID in any way. Only in this way can we foster a culturally respectful and safe environment for physicians to learn and to serve their patients in Ontario.

Thank you for your time.

The Chair (Mr. Peter Z. Milczyn): Thank you. Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you for being here and bringing your ideas forward. It's interesting that the University of Toronto, which is a world-renowned university—it's not because I went there; it's an amazing facility—but the fact that they are actually teaching doctors to participate in their conscience beliefs and not go forward, so the fact that our academic institutions are training physicians to be individuals, for the best of their patients, and that we have a college, the only one in any jurisdiction that we know of, to want to go against the conscience beliefs of doctors.

Are you seeing a lot of stress or consternation from students that you're teaching or mentoring?

Dr. Maria Wolfs: Well, it's interesting. May I answer your question with a little bit of historical background and then speak to what I'm seeing on a daily basis?

Mr. Jeff Yurek: Sure.

Dr. Maria Wolfs: Twenty-five years ago, it was routine that when a woman was anaesthetized under general anaesthetic, medical students and residents, without her consent, would perform pelvic exams as a way to learn the procedure. Why does that not exist now? Because medical students in residence complained that they found that morally abhorrent. We enshrined conscience protection and it resulted in appropriate patient rights.

It sounds egregious right now, but that was happening 25 years ago. One of my colleagues four years senior—and this has all been documented, but it was because trainees objected.

So absolutely, there has never been a more culturally diverse set of trainees. I just finished participating in medical school admissions a few weeks ago and it's beautiful to see that. Yet those who are objecting conscientiously are worried that they might not be able to practise in areas that are either remote, because of this need for effective referral, or in areas such as palliative care, critical care and oncology. I've definitely heard that. In mentoring students on choosing specialties and on deciding where to practise at the end of those, these questions are coming up. This isn't hypothetical.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas?

M^{me} France Gélinas: I'm sorry. I had to step out for a minute. Could you, in your own words—

Dr. Maria Wolfs: I could start again.

M^{me} France Gélinas: Really, really quickly, could you, in your own words, tell us why a referral is being seen as being part of MAID?

Dr. Maria Wolfs: Referral is co-operation, ultimately; if you wanted the simple one line. If it requires my referral to happen, it requires my consent. Therefore, I'm consenting to something that I'm fundamentally opposed to.

With that comes an erosion of moral integrity that eventually will lead to me having none. So part of my question about whether or not we want our physicians to practise with moral integrity—I don't think any patient would deny that.

Now, if a patient requests something that I cannot be involved in, they need to have alternatives to be able to self-refer to care coordination or a program, but this in no way means that I'm going to abandon them in any way. In fact, this is a call for even greater help. That's why I went into medicine.

M^{me} France Gélinas: To help people.

Since the law has changed, have you had any of your patients approach you to talk about medical aid in dying?

Dr. Maria Wolfs: No, I haven't, but several medical students in residence have shared stories where this is now sort of becoming one of the options offered to patients at the end of life. But personally, I'm not involved in patients who are directly at the end of life.

M^{me} France Gélinas: What you're telling me is that some of your students told you that they don't wait for the patients to talk about medical aid in dying, but it's actually being promoted or offered to them?

Dr. Maria Wolfs: I wouldn't say "promoted," but "offered" is one possibility of many at the end-of-life transitions.

M^{me} France Gélinas: Is this in the hospitals right here in Toronto?

Dr. Maria Wolfs: Yes.

M^{me} France Gélinas: Okay, thank you.

Dr. Maria Wolfs: But, generally, these aren't new ideas for patients because there certainly has been enough media coverage that people know that medical aid in dying is legal and that there are physicians performing it.

M^{me} France Gélinas: But to me, it's still different when a client requests to talk about this versus a physician offering it as a path of treatment.

The Chair (Mr. Peter Z. Milczyn): From the government—

Interruption.

The Chair (Mr. Peter Z. Milczyn): Dr. Wolfs, if you want to wait, there might be some questions from the government side, but we do have to recess to go and vote.

Dr. Maria Wolfs: Sure. I was wondering if that was a fire alarm. Strategically saved by the bell.

The Chair (Mr. Peter Z. Milczyn): The committee is recessed for 10 minutes.

The committee recessed from 1609 to 1619.

The Vice-Chair (Ms. Ann Hoggarth): We're going to resume the hearing now. We will go to MPP John Fraser.

Mr. John Fraser: Chair, very quickly, I just have a motion here I'd like us to consider right now. It's with regard to sittings and time. With the indulgence of the committee, can I—do we have copies of this?

The Clerk of the Committee (Mr. Eric Rennie): I do.

Mr. John Fraser: Thank you. I'll be very quick. Everybody is going to get a copy.

I move that the Chair request of the House leaders that a motion be moved in the House authorizing the committee to meet for an additional hour from 1 p.m. to 2 p.m. on Thursday, March 30, 2017, for the purpose of public hearings on Bill 84.

The Chair (Mr. Peter Z. Milczyn): Any discussion? All those in favour—Madame Gélinas?

M^{me} France Gélinas: Just procedure: I thought that we could not move motions; you had to table it one day and move it the next.

The Chair (Mr. Peter Z. Milczyn): If the members have been recognized in committee, they have the ability to move a motion at that time.

M^{me} France Gélinas: Right on. I didn't know that.

The Chair (Mr. Peter Z. Milczyn): Any discussion on the motion? All those in favour? Opposed? That motion is carried.

When we left off, Dr. Wolfs had done her presentation. The final round of questions was left to the government side, if there are any questions.

Mr. John Fraser: I just want to thank you very much for your presentation—we want to thank you very much for your presentation. In the interest of making sure that

all deputations can be heard today, I'm not going to ask you a question. Thank you very much.

The Chair (Mr. Peter Z. Milczyn): We would run out of time, is what he's saying.

Mr. John Fraser: Yes, we would run out of time for some people who have come a long way.

Dr. Maria Wolfs: Sure.

The Chair (Mr. Peter Z. Milczyn): If you do wish to make a written submission to the committee, you have until 6 p.m. next Thursday, March 30.

DR. GERALDINE JODY MACDONALD

The Chair (Mr. Peter Z. Milczyn): Our next witness is Geraldine Macdonald. Good afternoon. You have up to six minutes for your presentation, which will be followed by a round of questions beginning with the New Democratic caucus. If you could please state your name for the official record as you begin.

Dr. Geraldine Jody Macdonald: Thank you for welcoming me to the committee to discuss my concerns and suggestions about Bill 84. My name is Geraldine Jody Macdonald—I usually go by Jody—and I am a registered nurse. My nursing career has included being a visiting nurse caring for dying patients, a public health nurse, a childbirth educator and a nurse educator at the University of Toronto for the past 30 years. Today I am speaking as an individual registered nurse.

The Ontario government wants to provide patient-centred care for patients requesting MAID. Patient-centred care is a shared goal of all health professionals. I hope the Ontario government also agrees that we need to protect health professionals' freedom of conscience and religion, enshrined in the Charter of Rights and Freedoms along with the rights to protection against discrimination.

As a nurse who requires conscience protection related to my nursing ethics and my Catholic values, I propose four amendments to Bill 84.

(1) The most effective way to provide patient-centred care for patients requesting MAID is to have a central service that coordinates these services that patients can access themselves as needed. This would have the added benefit of removing the need for the health professional colleges to state that members with conscience objections must directly refer patients to such services. It would also allow agencies to participate voluntarily, and thus focus this work in agencies that wish to develop this expertise. I propose that the government of Ontario work hard to ensure that in setting up such a service, they ensure that patients and their families are able to access such a service independently. This will require effective public education.

(2) Your committee can propose new conscience protection intent/language to be included in Bill 84. This new intent language would need to ensure (a) that all health professionals in Canada have the right to conscience protection in relation to MAID; (b) that the public be educated about the importance of ensuring that health care professionals have the right to conscience

protection and freedom from discrimination; (c) that the public be reassured that they will have reasonable access to MAID from the voluntary agencies and health professionals who wish to engage in MAID; and (d) that religious patients who do not wish for MAID have the right to request that they not be asked about MAID.

(3) The June 2016 legalization of MAID is having an impact on students in health professions in Ontario. Current students have asked me—and, I might point out, not inside my faculty, but outside at events where they feel safer: “Is it possible to continue my faith if I am a student in health professions in Ontario today? Can I wear my necklace with a cross on it, or will this mean that I will fail, as my Christian values will be exposed? Is there any specialty in medicine besides pathology that is safe to practise in?” These are difficult questions to answer at this moment in time.

High school students have asked, “Is it safe for a religious person to enter nursing, medicine, pharmacology or social work?” High school and university students in Ontario need your help. You have the opportunity to clarify that all students are welcome to apply to and continue in the health professions in Ontario. You can clarify that in Ontario, all health professional students’ diversities are respected, valued and protected, including religious values. When Bill 84 is revised, please include language and intent that clearly extends robust conscience protections to our health professional students.

(4) The committee is encouraged to consider the importance of relationships between health professionals and their patients. Patients and family members frequently ask their health care providers questions about treatment options, such as, “What do you think about this treatment option? What do you think would be the best choice? What would you do if you had this choice?”

I have answered many such questions in my nursing career. I have listened when patients have expressed fear of dying, fear of pain, loneliness, uncertainty and despair. I have had patients who are terminally ill ask me if I would help kill them if their quality of life became terrible.

1630

But I learned that my role as a nurse is to maintain hope; hope initially for a cure, then hope for time and then hope for a dignified, pain-free death. I have felt comfortable letting patients know that my nursing values and my personal values would not let me participate actively in ending their life, but I’ve always assured my patients/clients that I would be there to support them.

I learned that someone who had said that they would never want to live if they could not walk adjusted to canes, then a walker and then a wheelchair. Later, they might say that they would not want to live if they were bedridden. I would hold their hand and say I would be there with them. Hopefully, their family would be there with them. Maybe their grandchildren would come over and bounce on the bed with them. They adjusted and learned to value their good moments. Finally, when they did die, I supported the family left behind.

This is the kind of relationship that makes a difference in the lives of patients and that ensures excellent patient-centred care. It has been a privilege to serve the people of Ontario for the last 43 years.

Today, if I were working with dying patients, I would not be able to be as open with them. I am effectively silenced if asked about MAID. So I would ask you to consider what you wish to say to the colleges that govern health professionals. Do you want them to silence health professionals who have a conscience objection to engaging in MAID? Please consider this carefully and ensure that you address this in Bill 84.

For 40 years, I was a member of the RNAO, the Registered Nurses’ Association of Ontario. About a year ago, just prior to the June 2016 vote, I wrote asking for support around my concerns around this issue. I wrote to the consultant that I was supposed to write to; I was ignored. I asked for a survey to see how many other people shared my concerns. Again, as far as I know, no survey was taken. Therefore, I subsequently, in the fall, did no longer join the RNAO, so the RNAO no longer speaks for me.

Thank you for considering my concerns and suggestions.

The Chair (Mr. Peter Z. Milczyn): Thank you very much. This round of questions begins with Madame Gélinas.

M^{me} France Gélinas: Thank you so much for coming. I thank you for your deputation.

You made it clear that you no longer belong to the RNAO because, I take it, RNAO has taken the stand that they want mandatory referral.

Dr. Geraldine Jody Macdonald: Well, that and the fact that they were not in the least bit interested in my concerns and they were not responsive when I asked for support around it.

M^{me} France Gélinas: Okay. As far as I know, the College of Nurses of Ontario doesn’t have a mandatory referral that I know of. Do you know otherwise?

Dr. Geraldine Jody Macdonald: Yes, we do. I am not allowed to speak about MAID in any negative terms to any patient. So if asked about MAID, I’m not allowed to respond. I can only refer them to someone else. I can’t remember if the current language—it has changed so many times—says “refer” or “transfer,” but the language is there.

M^{me} France Gélinas: That’s news to me. Okay. Would you be willing to share that with us?

Dr. Geraldine Jody Macdonald: Yes, it’s on the website.

M^{me} France Gélinas: My last question is, since the federal laws have changed, have you had any patients come to you asking to gain access to MAID?

Dr. Geraldine Jody Macdonald: No, because I only really see pregnant people in prenatal classes. Otherwise, I see students.

M^{me} France Gélinas: Oh, okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you. Mr. Fraser, three minutes.

Mr. John Fraser: Thank you very much, Chair.

Thank you very much for being here today and for the work that you do every day.

In the interest of time, I simply want to reassure you that a care coordination service is the intent of the government. That's important for access for people and creating pathways to the services that people need. So I just want to thank you. I'm just reducing my time so we can ensure that all the deputations get to speak this evening.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair.

I'll be brief too, in the interest of time. I appreciate the government creating this care coordination service, but I feel that you still have to deal with conscience rights at the same time. You can't have it one way or the other; both have to occur. Do you concur?

Dr. Geraldine Jody Macdonald: Absolutely. It's absolutely essential.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Macdonald, for your presentation today. If there's anything further in writing that you'd like to submit, you have until 6 p.m.

Dr. Geraldine Jody Macdonald: Yes, I submitted it.

The Chair (Mr. Peter Z. Milczyn): Thank you.

CANADIAN CATHOLIC BIOETHICS INSTITUTE

The Chair (Mr. Peter Z. Milczyn): Our next witness is Ms. Moira McQueen. Good afternoon.

Dr. Moira McQueen: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have up to six minutes for your presentation, and if you could please state your name for the official record as you begin.

Dr. Moira McQueen: My name is Moira McQueen. I'm the executive director of the Canadian Catholic Bioethics Institute and a moral theologian at the University of St. Michael's College.

Thank you for allowing me to speak today, because this is an issue that's very, very important to everybody. I think my particular interest is in the protection of conscience, because this is an area that is of grave importance to so many people. I know you've had many people speaking already, citing the Canadian Charter of Rights and Freedom's protection of conscience and the Universal Declaration of Human Rights' protection of conscience. I really hope that people pay close attention to what those say, especially around not just the freedom of religion, but the practice of the religion.

Very often, for many people—and not just Catholic people either—this conscience question comes into play when they're being asked to deal with procedures that go totally against their conscience. The big problem, which I know has been referred to several times and will be again, is this stance of the College of Physicians and Surgeons of Ontario demanding an effective referral. For people to whom this is an area where they just cannot perform

these procedures, they also, then, cannot make what is called an effective referral in any sense whatsoever.

I know that the one thing that I feel really strongly about—the law has already passed, so in terms of what can be done—is protection of conscience, but everyone's conscience. With effective referral, even if there is a third-party agency, which many people have been requesting because it does seem as if that is a way of handling the situation, physicians who are against these procedures do not want to refer directly to that third-party agency.

My stance, really, is that everything should be patient-initiated. Partly I base that on the fact that so much is made of the need for consent to access MAID procedures. That competence to consent demands a fairly high standard of people. Therefore, I think that if they're competent to request the procedures, they're perfectly competent also to access a third-party agency by themselves. There will probably be information about that; there will be education, as well. So on that basis of competency, that capacity for consent, I don't see the necessity for physicians or nurse practitioners to be made to make an effective referral.

I think, just looking at it fairly reasonably, the language involved in that demand is that they must refer, which, really, to me, implies an element of compulsion. It also means that if someone refuses to comply on conscientious grounds, there will be possible consequences. I'm not really too sure, if we're in a society where we are talking about goodwill, a pluralistic society where we make many accommodations for other people, why there can't be an accommodation here for that particular stance on conscience. I'm really not sure why the CPSO is actually insisting on this when there are alternatives, one of them being a third-party agency, again, with the standard that patients can access it themselves or definitely find information on how to handle it.

I think the government of Ontario is perfectly aware of this whole question of goodwill. I do a lot of community education in different parishes and other groups, and the questions that I've had over the past two years, even pre-MAID legislation, have very often revolved around this area. People know that once a law is in place, even if they want to do something about that eventually—at the minute, what can they really work for? I think one of the important things is this whole protection of conscience rights.

I'd like to stress again that I'm really happy to live in a pluralistic society like Ontario, and so it seems to me, again, perfectly reasonable that there could be accommodations for conscience.

I really think that's all I would like to say at the minute.

The Chair (Mr. Peter Z. Milczyn): Thank you. We'll start this round of questions with Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation.

We were talking about the care coordination and creating a pathway for people that was patient-facing. That pathway is something that is a range of options for

people, and includes things like access to palliative and end-of-life care, and the kind of consultation that's necessary for people to make a decision.

1640

What is your position on the care coordination service?

Dr. Moira McQueen: My position is that I think it's a very good idea but, relevant to that, still not being a doctor or a nurse practitioner referral. The idea that there is something there that helps people to access all these different procedures that you're mentioning makes perfect sense to me in that we could include access to MAID procedures, too. I really have a very strong stance to protect physicians' and nurse practitioners' consciences, but also to look at other people who want access. To me, this is a kind of win-win situation, if there is such a third-party organization that people who want the procedures can access them themselves. I don't really see that there's a necessity for a direct referral.

Mr. John Fraser: Seeing as that pathway is a pathway and that, in my experience, many of the physicians who come to me and speak about their conscientious objection—it would provide an opportunity for those physicians to continue on that pathway in some shape or form. I think we heard that described here earlier today. I would just like to suggest that to you. It's not really a question; if you want to respond to it, you can. I think it creates that space and that pathway for the physician who is torn to be able to provide that patient with the services and with the skills that they have, and allows them to be dedicated to that patient.

Dr. Moira McQueen: I really think I would probably just be responding in the same way I already did. But I take what you're saying to heart.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Thank you for your deputation today and for bringing forth information.

As I've said continually, I've heard all afternoon, except maybe from a few deputants, that the care co-ordination the government is proposing, much like Alberta's, is much supported; I don't think you'll get any argument from anybody who has come forward. But I have yet to hear from the government, "We want to look after people's individual rights and freedom of thought." We haven't heard that yet.

The CPSO is saying that in their eyes, this doesn't affect anyone's conscience thoughts, but in my opinion, they're deciding what someone thinks. Could you please touch upon that?

Dr. Moira McQueen: Right. I think this is where there is a definite difference of thought—it's not just opinion—in this matter. It does go back to how important the role of conscience is.

A different stance on conscience is not just a matter of a difference of opinion. When I hold something really of great value in terms of my conscience, then I will not go against that conscience. It's not just a decision in my mind, it's not just one option against the other; it's

actually something that really, in a way, represents me. I am my conscience in that sense.

Most of us become who we are because of our moral choices in life, from that perspective. We reflect those values in everything that we do. Just as with other areas I think are morally wrong, I wouldn't be involved, then, in saying—I don't have to do those procedures, but the idea that I would then have to refer to someone else who does the procedure seems to me totally contrary in terms of conscience. If there is something I think is seriously wrong and I won't do myself, I can't ask somebody else to do the same action.

It's really about the action in those cases, and I think that's what's so important about conscience. I think that's why conscience rights are enshrined in all our different legislations to protect people in these very difficult dilemmas. But when people are being reasonable and when there is goodwill, conscience is respected across the board and necessary accommodations can be made for people who have different values from other people. It's not as if it's impossible, so I really appeal to reason and goodwill in these areas.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas?

M^{me} France Gélinas: I agree with you: Everything is possible with goodwill.

Before the bill was tabled, were you afforded an opportunity to have a safe forum to air your views, to be heard, to be engaged in the development of the bill we have in front of us?

Dr. Moira McQueen: I wasn't involved in the development of the bill as such, but I have been involved in the public domain, talking about these areas, for probably a decade.

M^{me} France Gélinas: But the government never sought your views to make sure they were respectful of your views before they tabled the bill?

Dr. Moira McQueen: I would say they didn't.

M^{me} France Gélinas: The argument we hear is that if we go with the care coordination and take away the mandatory referral to be respectful of conscience rights, some people may fall through the cracks. Some people are in such vulnerable states that, although they would qualify for medical aid in dying, they would find themselves at a time where their only hope of help is their physician. How do we address those?

Dr. Moira McQueen: I've heard that concern addressed before. It's very difficult for me to imagine that, in our society, someone would be so completely alone that only a physician was the person to whom the person could turn. Even turning to a physician implies already being in a hospital or a doctor's office, relating to other people or that kind of thing. Most of us are tied into social services. I don't really believe that someone is completely alone in these situations. People very often use the term, "You're abandoning the patient," which I think is kind of awkwardly emotional in these circumstances.

I go back to the point I made earlier: To be able to be competent to request MAID procedures demands a fairly high level of competence. If I actually can request the procedures, I can also access any sort of third-party agency.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much for your presentation this afternoon. If there's anything further you would like to submit in writing, you have until 6 p.m. next Thursday, March 30.

Dr. Moira McQueen: Thank you.

DR. ELLEN WARNER

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Ellen Warner. Good afternoon. You have up to six minutes for your presentation. If you could please state your name for the official record as you begin.

Dr. Ellen Warner: My name is Dr. Ellen Warner. I would like to thank the committee Chair and Mr. Rennie for giving me the opportunity to speak to you this afternoon.

I'm going to share something with you that I don't tell anybody: I graduated at the top of my University of Toronto medical school class. That's relevant information because I want you to understand how shocked my classmates and family were, after my graduation, when I chose to enter one of the least popular specialties at that time: medical oncology, the discipline that uses drugs like chemotherapy to treat cancer that can't be cured by surgery or radiation. Back in the early 1980s, when I started my oncology training, cancer was the dreaded C-word nobody talked about, a death sentence. And chemotherapy was the other dreaded C-word: a terminal ritual of vomiting and hair loss.

So why in the world would I choose medical oncology? Because it provided me with two exciting challenges: As a researcher, I could help find more effective and less toxic treatments, and as a clinician, I could provide despairing patients and families with realistic hope—sometimes hope of cure, often hope of extension of meaningful life, and always hope of comfort—at least emotional comfort, and usually physical comfort too.

I've been rewarded with the privilege of watching how with each passing decade, our ability to cure cancer, prolong life and minimize treatment side effects has improved by leaps and bounds. Over the last 30-plus years, I've treated thousands of cancer patients, but unfortunately, many hundreds of them have eventually died of that cancer.

What I've observed is that most patients with incurable cancer want to get anti-cancer treatment as long as there's any chance that treatment might prolong their life. But at some point, most of these patients, quite appropriately, choose to stop active treatment and let the disease run its relentless course. Fortunately, thanks to advances in the specialty of palliative care, the great majority of these patients have died comfortably and peacefully.

Not a single one of my patients ever asked me to actively do anything to hasten death. That's why I was quite shocked when last June, the Supreme Court of Canada legalized medical assistance in dying, MAID. Who were these patients who wanted it?

I asked some of my palliative care colleagues who treat a lot more dying patients than I do, and they assured me that they had seen such patients over the years. When I asked these physicians about their willingness to participate in MAID, some were comfortable with the idea and others most definitely were not. This latter group share my personal belief that our duty as physicians is to prolong life whenever that's possible and reasonable, and to never do anything to deliberately shorten life.

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We live in a democratic, free country that at least in theory embraces diversity of values, beliefs and needs. The ruling to legalize MAID was based on the desire to respect the beliefs and needs of that small number of patients who want their life terminated before its natural end. There are an adequate number of health care providers who are willing to ensure that these patients' needs are met.

However, just as it would be unthinkable for any patient to be coerced into accepting MAID, it should be equally unthinkable for any health care provider to be coerced into participating in MAID; either actively, by supervising or performing the procedure, or passively, by referring the patient to someone else who is committed to performing the act.

But this coercion is happening. At my institution, physicians are being bullied into accepting the role of the most responsible physician for MAID patients. This forces these physicians to be legally responsible for the MAID act, even when that goes against their conscience or religious beliefs. It gets worse: At one of our staff meetings, a psychiatrist stood up and announced that any physician who didn't actively support MAID should not be working at our hospital.

Those of us who do not want to be involved in MAID are equally horrified by the current requirements of our college, the CPSO, that we "effectively refer" patients who ask about MAID to a physician who is willing and eager to carry out the act. Failure to do so could subject us to severe disciplinary measures.

Members of this committee: Ontario health care providers who conscientiously object to MAID need your recommendation for legislation to protect us. Without it, there will be severe negative consequences, not just for ourselves but also for future graduates of health care professional schools. For example, medical students who do not want to ever be involved in MAID will feel compelled to enter one of the very limited number of specialties in which MAID would never be an issue. Were I a medical student today at the University of Toronto across the road, hoping to practise medicine in my own province of Ontario, I would not be able to choose to be a medical oncologist.

The group with the most to lose in the absence of such legislation are the patients—the group we're all trying to help. If, by default, all physicians who treat incurable diseases have to be advocates for MAID, those patients will lose their right to choose a different kind of physician: a physician willing to fight together with them for every precious day of life.

Please amend Bill 84 to provide conscience protection for health care providers so that we, our trainees and especially our patients can retain the choices we all deserve as free citizens of Ontario.

Thank you for your attention.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor. We'll start this round with Mr. Yurek.

Mr. Jeff Yurek: Thank you, Chair. Thank you very much for coming in, Doctor, and giving this great deputation.

In your opinion, if the care coordination system is set up and patients, families and caregivers are able to access a care coordinator, and doctors, nurses, pharmacists and dentists etc. were given their conscience protection, do you feel there would be adequate access to medical assistance in dying in this province?

Dr. Ellen Warner: I do, for all the reasons given by the previous speakers.

Mr. Jeff Yurek: Have you any contact with any physicians in Alberta who currently utilize this method, and do you have any comment on what their ideas have been?

Dr. Ellen Warner: I haven't personally. I've heard through the grapevine that it works well, but I haven't personally spoken to any of them.

Mr. Jeff Yurek: Have you shared your concerns with regard to conscience protection with your college—with regard to effective referral?

Dr. Ellen Warner: Specifically, I have not, but I've spoken to other people who are doing so.

Mr. Jeff Yurek: You mentioned about a colleague standing up and saying, "You should be performing this or you shouldn't be working here." Do you feel that pressure? Is there a stress level that is increasing in physician circles?

Dr. Ellen Warner: There's a horrendous stress level at our hospital. Physicians are afraid to speak up. Physicians are afraid that they will lose their jobs if they say anything. Even just speaking to my colleagues about this, we use alternative email addresses and we speak in code. We feel sometimes like we're in some sort of dystopian novel.

Mr. Jeff Yurek: A culture of fear is a way to try to control the masses, I would imagine, and that's terrible that we're in this state here in this province. Hopefully, we can do something to alleviate that, going further in this committee.

Dr. Ellen Warner: I certainly hope so. Thank you.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas.

M^{me} France Gélinas: Thank you for coming here. From the beginning, I have said that we saw this coming.

We saw the Supreme Court. We saw the Carter case. We saw the bill that came from the federal government. Yet, our government, the provincial government, did nothing so that good people like you who wanted a safe place to have a discussion to find a middle ground, to find a compromise that would respect the conscientious right, as well as provide access—we never had a safe forum.

What you've shared with us today is the proof of that. There was never a safe place created so that Ontarians could have this discussion. I believe that every hurdle can be overcome if you create those safe places and give people the chance to be heard without being discriminated against.

I'm horrified by some of what you've shared with us: that it has come to the point where your place of work is starting to put pressure and your place of work is starting to become dysfunctional. We need you, at the end of the day, to be at the top of your game in order for your patients to receive top-quality care. The whole thing worries me.

Your ask, we have heard before, but I don't want to put words in your mouth. So what exactly would you like to see in the bill?

Dr. Ellen Warner: I want to see a number of things. I want to see doctors protected so that we don't have to participate in this. Certainly, this idea of being the most responsible physician should never be something that a conscientious objector should have to do, and we shouldn't have to actively refer.

I wouldn't have a problem referring patients to some sort of coordinated care system that gave multiple options, including palliative care, including good psychiatric health etc. I don't want to have to directly refer to a physician who is going to, no questions asked, go ahead and proceed with MAID. So that's the protection for our physicians.

We also need protection for our patients. Right now on our ward, we have patients who are getting MAID done next door to a patient who is being actively treated to fight for their life. The same health care professionals are expected to work with both at the same time. I don't think that that's appropriate either. I think that institutions that want to carry out MAID—that's fine. Do it in a separate part of the hospital, in a separate ward, in a separate corridor—something where you don't have to have this conflict of interest displayed.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and choosing medical oncology. I want to assure you that that care coordination service is a commitment that the government has made. The minister has made it very clearly. I want you to leave with that assurance today.

I'm going to be brief, but I just want to, from the perspective of consultation—I have to put this on the record, if you can bear with me: The government held 11 town halls, nine in English and two in French. The English sessions were held in Sudbury, Ottawa, Toronto,

Sault Ste. Marie, Barrie, Kingston, London, Thunder Bay and Windsor. French sessions were held in Sudbury and Ottawa. Thousands of online submissions—and a lot of focus group work.

It's something that's new to our society. We know that. It may have happened in other jurisdictions. So there can be the sense there that we all haven't had a chance to find our way through this. I think that it's critical that we do that, because we have to create—and I think it's in your submission—those kind of pathways that allow access to patients for a range of services.

I'm trying to make sure we stay on time here so everybody can get their deputations in. I just want to thank you again for being here and making your presentation.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Warner. If there's anything further you'd like to submit in writing, you can do so until 6 p.m. next Thursday, March 30.

Dr. Ellen Warner: Thank you very much.

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DR. JANE DOBSON

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Jane Dobson. Good afternoon. You have six minutes for your presentation, and if you could please state your name for the official record as we begin.

Dr. Jane Dobson: Jane Dobson. Thank you for allowing me to speak with you today regarding Bill 84, which addresses medical assistance in dying. I am a family doctor and I have been practising in Hamilton for the last 27 years. I care for patients from the very young to the very old. I provide palliative service in my patients' homes, in hospice, and in retirement and nursing homes.

I became a doctor to help heal and care for my patients, not to kill them. I am deeply disturbed that I am currently being commanded by the College of Physicians and Surgeons of Ontario to refer patients to be euthanized even though I am totally morally opposed to it. If I don't comply, I face fines and the possible suspension of my licence. I do not think forcing a doctor to violate their conscience will result in better patient care. In fact, it will weaken the doctor's decision-making and make their care less reliable.

When someone asks me why I can't just refer for medical assistance in dying, since, "After all," they say, "you aren't giving the lethal injection," I ask them if they would mind if someone just referred someone to a hit man, rather than being the hit man themselves. We aren't talking about facilitating jaywalking. Surely they can see that it is aiding and abetting the killing of a human being, someone that I took an oath to heal and protect. I cannot aid and abet such a moral crime.

No other country in the world where euthanasia has been made legal forces doctors to violate their conscience in this way. Eight other provinces have found morally acceptable ways of balancing doctor and patient rights. I

want to emphasize that I am not trying to block or stop providing care for my patients who request this. I discuss all the options with them, and if they decide they do indeed wish MAID, I will continue to care for them right up until they receive the MAID procedure. I just cannot refer them for this.

It is also unnecessary to force me to refer my patients for MAID when there are good alternative models being used right in our country. Apparently this has been well discussed already, so I won't go into the Alberta model, but it does include a public telehealth phone number. There is no need for a physician's referral or the delay involved with this.

When patients come to my office, by themselves or with their caregiver, I would be able to give them the telehealth phone number, but I could not refer them directly to a care coordination service, because it includes medical assistance in dying. Only through a public telehealth number could I do this. When they are at home, I similarly would provide this telehealth number to them or to their power of attorney, or, if they are that sick, of course they have a CCAC provider who is involved in the end-of-life care and can facilitate this.

I am asking that Bill 84 be amended to include a conscience clause for physicians so that the rights of both patients and physicians will be respected. This bill does provide legal protection for doctors who perform medical assistance in dying. Why would there not also be a provision for the rights of doctors whose consciences are not allowing them to be involved in this?

Throughout my career, I have seen patients receive a traumatic diagnosis and then feel so overwhelmed that they want to end their life. However, with the support of their health care team and their family and friends, they can regain hope. No one knows what the future holds or what medical advances may occur, nor what additional help could bring back purpose and meaning into people's lives.

Several patients come to mind. One patient in her late fifties was told she had advanced cancer. She had a 20% chance of survival. She developed marked depression, but with ongoing treatment and the love and help of her family, she persevered. Now, seven years since diagnosis, she is enjoying a full life with her husband and family. What a horrible waste it would have been if she had ended her life.

Another patient in his early sixties was told he had only two years to live due to a progressive lung disease. However, he continued to live his life on his own terms and he lived it fully for the next five years, with his family and his many pets by his side. What a loss it would have been to him and those around him if his life had been terminated early.

Also, a young patient in her twenties was diagnosed with a neurological disease which rapidly progressed. Things looked very bleak. If she had ended her life at that time, she would have missed out on the new drug that was introduced that did help her regain a lot of function

and the ability to enjoy the wonderful life she now shares with her husband.

My own brother, at the age of 50, became acutely suicidal when he was told that his tonsillar cancer had spread to his brain. Instead of being killed, which would have happened these days, he was admitted to the psychiatric ward for therapy. His mood rebounded and he spent the next months of his life receiving care, first at home and then in hospice, where he was able to reconnect and reconcile with old friends and family members and he spent meaningful time with his two young sons and his wife. He was so glad that he did not kill himself or be aided in this. He was truly grateful for the extra time.

I became a doctor to help my patients live and to give them hope, not to kill them. I will not be able to continue to practise medicine if I am compelled to refer my patients for euthanasia; I will be forced to retire early. I cannot see how this will be beneficial to my patients' care.

I need your help. I am asking you to help me to be able to continue caring for my patients. I want nothing more than to be allowed to practise good family medicine. I want to be allowed to give good palliative care, to relieve suffering and provide compassion in all the settings where my patients reside. I want to be allowed to continue to give them hope and affirm that they do indeed have a life worth living. We must have a conscience clause added to Bill 84 to ensure that both doctors' and patients' rights are respected.

Thank you so much for your help in this matter.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Dobson.

Madame Gélinas, you have three minutes.

M^{me} France Gélinas: Thank you, Dr. Dobson, for sharing this with me, with us.

You mentioned that you worked in long-term-care homes.

Dr. Jane Dobson: Yes.

M^{me} France Gélinas: The examples that are given to us to say that mandatory referral has to be there are often linked to somebody very frail who meets all of the eligibility criteria and who has no support. We often hear about people in long-term-care homes who haven't had visitors since the day they were admitted. They still meet the criteria for being eligible for MAID—

Dr. Jane Dobson: Meaning if they were competent?

M^{me} France Gélinas: That's right.

Dr. Jane Dobson: It's the future that looks bleak for them when—it's their future things, but currently they have to be mentally competent, yes.

M^{me} France Gélinas: What I'm getting at is, can you foresee that somebody would have their only access to MAID through their care team, because this is the only access they have? I have in mind somebody in a long-term-care home who hasn't had visitors in 18 months.

Dr. Jane Dobson: Right. Well, there are many different people involved in their care at the care home, not just me. There's health care aides, there are the nurses, there are the RPNs and there's the administrator

right? They all have different conscience problems or not with MAID.

Currently, our nursing home doesn't have a policy on it because there's nobody—I think there are maybe about two people who would be capable of making that decision, and no one has. But there definitely are people who would do it and there are people who wouldn't do it, so if I were asked, I could just tell them that I couldn't do it, and that person would be transferred to somebody else.

Nobody is alone. There are so many caregivers there.

M^{me} France Gélinas: So another caregiver could help out.

In any of your workplaces, is there a procedure in place to help each other out so that the people who have conscience issues can refer to a colleague or anything like this in the meantime? How does it work?

Dr. Jane Dobson: In the meantime—at my office there is no system, no, because everybody's afraid of the effective referral.

M^{me} France Gélinas: Yes.

Dr. Jane Dobson: Yes. If there was no compulsion, if there was even a telehealth number that I even could give out, then there would be no problem. I think with the coordination service you're talking about, which John Fraser mentioned, there's nothing about a public telehealth number. But Alberta has that.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser.

Dr. Jane Dobson: Unless—is there a telehealth number in your service?

Mr. John Fraser: Thank you very much, Dr. Dobson. What I have described is that the government has committed to a care coordination service. I believe that that care coordination service has to have a host of things in there, because it's a pathway. As a general practitioner, I assume, who provides palliative care—and thank you for doing that, because we have a really critical challenge inside family medicine about people being able to provide that service. It's about choices, right? It's making sure that people have access to those things that will help them make a decision. Having access to some symptom relief that you may not have gotten because of the skill level of the practitioner who was serving you, who didn't know that there was a medication that could reduce your spasms by a multiple of 30, which made your life different—that care coordination service is something that we're committed to establishing, and it's a pathway. It's an important pathway—

Dr. Jane Dobson: Will it include a telehealth phone number?

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Mr. John Fraser: I don't know specifically what the telephone number is—

Dr. Jane Dobson: Because I can show you the Alberta model that includes it. If you like, I'll leave it here for you.

Mr. John Fraser: This is something that we have been talking about with a number of individuals across—

Dr. Jane Dobson: Okay, I'll leave it here. I'll submit it. You'll see it.

Mr. John Fraser: We have seen that, is what I'm saying—

Dr. Jane Dobson: Have you? Great. And you've proposed it in your model?

Mr. John Fraser: I'm not quite sure what the telephone number is, but—

Dr. Jane Dobson: It doesn't have to be the same number. That would be inappropriate. That would be for Alberta.

Mr. John Fraser: I guess what I'm saying is that this is not something that we're doing in isolation. This is something that we've done in consultation with, what's the best way to make sure that we get access to those services—

Dr. Jane Dobson: And what about your commitment to a conscience clause? Because so far, all you've mentioned is the coordination service. You haven't talked about the conscience clause.

Mr. John Fraser: I'll say exactly what I said—

The Chair (Mr. Peter Z. Milczyn): Doctor, it's the members asking questions.

Dr. Jane Dobson: Okay. Sorry, go ahead.

Mr. John Fraser: I ask the questions, but that's okay. I'll give you an answer, and it's the answer that I've given.

I think we've heard very clearly today that there are two essential rights in there that we need to balance. I'm not sure how you do that in that piece of legislation—

Dr. Jane Dobson: You just add a conscience clause. It's very simple.

Mr. John Fraser: Okay, and do you add a clause that ensures people get access?

Dr. Jane Dobson: You're going to do that by the care coordination service, which is not in Bill 84, right?

Mr. John Fraser: That's the question.

Dr. Jane Dobson: Yes.

Mr. John Fraser: I certainly appreciate that. We've heard that very clearly. I want you to be able to continue to practise, to continue to have people follow—that you follow them along that pathway of care. It's very clearly understood. I want to assure you that it is.

Dr. Jane Dobson: Yes, great.

Mr. John Fraser: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Thank you very much for being here. I do have to say that the government has committed to creating this patient self-referral system. I'll commit to putting this amendment for conscience protection, and hopefully they'll support that at the end of the day. But it will be on the table for discussion.

They are going to do that part—and I'm fully supportive of this care coordination. They can utilize the CCACs that they've just transformed. That covers the entire province, and that could create the system for access. Patients' access shouldn't be inhibited. But at the same time, we also need to ensure that patients' rights are protected. I'm giving you that. On our side, we'll give

you a clear answer on that, and we will ensure the government moves forward and get out of their way in creating this system to ensure people have access to MAID.

Dr. Jane Dobson: Okay. Thanks so much.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Dobson. If there is something further you'd like to submit in writing, you can do so until 6 p.m. next Thursday, March 30.

DR. CHANTAL PERROT

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Chantal Perrot. Good afternoon, Doctor.

Dr. Chantal Perrot: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have up to six minutes for your presentation. If you could please state your name for the official record as you begin.

Dr. Chantal Perrot: Chantal Perrot. Thank you for the opportunity to speak with you today about Bill 84. I trained as a family physician and have worked in Toronto for over 30 years. I have been providing MAID to patients since July 2016. With Dr. Ed Weiss, I co-founded MAID GTA, an organization of assessors and providers. We also have a website available to the public through which patients may self-refer. I am also a member of the Canadian Association of MAID Assessors and Providers, which is a national group.

Today, I want to share with you some of my experiences as an assessor and provider of MAID, with particular reference to this bill. I am a third-party assessor, meaning these are not patients from my medical practice. They are referred to me specifically for MAID through the Ministry of Health registry, other MAID assessors and providers, their physicians or their self-referrals.

I appreciate and support the amendment that protects physicians, surgeons and other persons assisting in the provision of MAID from a court action for damages, unless he or she is negligent. The amendment that ensures that a person receiving MAID is not denied life insurance or other benefits is also good and will be a relief to patients.

To protect the safety and privacy of those participating in MAID, the amendment disallowing freedom-of-information requests for information identifying individuals is very important. Fear of exposure and of harassment by those opposed to MAID is very real and may deter potential providers from providing MAID.

However, I do not think this protection should extend to institutions. Publicly funded institutions should be accountable and transparent, and the basket of services they provide should be readily available to the public they serve. This includes MAID. Patients cannot make informed choices if they do not know the policies and services provided by institutions or how those policies may adversely affect them by creating barriers to care.

The amendment to the Coroners Act to require reporting of MAID deaths to the coroner does not serve the public in the long run. Data on MAID deaths should

be tracked for statistical purposes, but we would be better served by a national framework. MAID deaths are planned and medically indicated, not sudden or suspicious, so there is no need to involve the coroner. Patients and their families have been frightened and faced further anguish and insecurity, knowing that these deaths are reportable and thus could result in an investigation with an autopsy.

For physicians and nurse practitioner providers, the paperwork and time involved in making these reports is excessive and unnecessary. The addition of a tick box for MAID on the death certificate should suffice. This would also facilitate removal of "suicide" as the cause of death on the death certificate, a label which adds further insult and stigmatization for the patient and their families and loved ones.

I understand, and I've heard this afternoon already, that there was considerable discussion about conscience rights as the bill was going through second reading—and currently. At present, the College of Physicians and Surgeons of Ontario has a policy regarding MAID which includes the requirement of effective referral. Even with this policy in place, over half of the patients that I have seen in the past nine months have suffered from lack of effective referral, meaning their requests for MAID were not acted upon in a timely manner. I can only imagine how bad it would be if there was no policy requiring effective referral at all.

Two patients whose physicians did not refer them contacted the BC Civil Liberties Association, which they had heard about in the media, and asked for help. Through a physician in Vancouver, they were then referred to me, but this resulted in delays of many months for these patients. Two patients made suicide attempts, trying to end their own lives when their physicians did not act on their requests for referrals. This led to further delays due to the subsequent refusal of referral on mental health grounds. This was totally inappropriate under the circumstances, as the patients were not clinically depressed and they had full capacity.

Some physicians tell patients to find their own assessors, go online to find out information about MAID, go online to get the forms etc. These are very ill, fragile, frail and vulnerable people, many of whom do not have the wherewithal to do these searches, some of whom are physically incapable of using a telephone, let alone a computer. To ask them to do this themselves is tantamount to patient abandonment. It is also cruel, imposing a tremendous burden on an already vulnerable person. Not all patients will have family members or friends who can help them navigate the system or advocate for them. If they do, these advocates can be accused of coercing the patient. The patient is then deemed ineligible for MAID due to presumed external pressure or coercion. This is a terrible bind for the patients and their loved ones.

The issue is not just effective referral; it is also effective and timely response to requests for medical information that is needed to make a proper assessment of eligibility. I have received referrals from the Ministry of Health registry, only to have the referring doctor not

return phone calls and not follow through on sending necessary information, again leaving the patient languishing in pain and uncertainty. In three cases, patients' family members went to physicians' offices themselves, picked up the records and delivered them to me. This requires a level of assertiveness and tenacity that not all patients or their support people will have and is an undue burden on them.

When patients self-refer, I still need the assistance of their doctors to obtain medical records and information as part of the assessment process. Doctors and hospitals make it very difficult for patients to request and receive their own medical information. Some doctors are telling their patients that they are not eligible for MAID and are thus denied even a referral for assessment. In the cases I have seen, the doctors have been wrong. They have clearly not been familiar with Bill C-14 and the eligibility criteria. These patients have suffered unnecessary delays in receiving assessments and accessing MAID.

I am only one of a number of physicians and nurse practitioners providing MAID in Ontario. I have no reason to think my experience and that of my patients is outside of the norm. This would suggest there is already a lack of effective referral for MAID in Ontario. The CPSO policy on effective referral balances the rights of true conscientious objectors with the rights of patients to access a legal medical service. The focus should be on enforcing the policy, not eliminating or eroding it.

For dying to be your first choice, the singular focus of your energy and attention, you must be suffering immeasurably. No one wants to die unless living is a worse option. Likewise, no family member or loved one of someone choosing MAID wants to see their person die. They choose to support the person they love and care for because they love and care for that person and want what is best for them from their—the dying person's—point of view. It takes great courage to choose MAID and it takes great courage and love to support someone through the MAID process. We should be supporting our patients and their families at this difficult time in their lives, not making it more painful, more filled with anguish, uncertainty, negative judgement and neglect.

Thank you.

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The Chair (Mr. Peter Z. Milczyn): Thank you. We'll start this round of questions off with the government side, Mr. Fraser.

Mr. John Fraser: Thank you very much for coming here and making that presentation and talking about the real-life experiences that you've had as a practitioner. As is evidenced by the hearings, we have different views and different sides coming forward and, as legislators, we have to find a path forward. I believe we can all come through this together.

What I'm concerned about is something that's maybe a little bit more technical. It's something in the health care system that really concerns me and that's transitions, and that's people moving from one setting to another, through a referral, waiting for something. Some of that

you can relate to what you're saying is perhaps a person's objection. But it didn't sound to me like that was the whole issue; that there was an issue around ensuring that somebody sent you some records or that you called the hospital and you had access to those things. Are you experiencing that?

Dr. Chantal Perrot: Yes.

Mr. John Fraser: So you're experiencing that not necessarily from a position of conscience rights but just access to getting what you need?

Dr. Chantal Perrot: I don't know. There is the issue of getting access to what I need. Whether the physicians who are referring are conscientious objectors, that I don't know. I hear from some of the patients, "My doctor is opposed. My doctor wouldn't refer me. They don't believe in MAID. My doctor doesn't think it's a good thing and so they won't help me"—those kinds of things. But whether that's the conscientious objection or religious, I don't know.

Mr. John Fraser: One of the challenges is making sure that people get to where they need to go.

Dr. Chantal Perrot: I have had patients who have been afraid to talk to their doctors for fear of their doctors' responses. So that too is an impediment for them.

Mr. John Fraser: So from the point of view of—we've been having some conversations about a care coordinating service. Do you have any views on that?

Dr. Chantal Perrot: I think for healthy, capable people a care service is terrific; you can access that. But for the patients I see, frankly, the difficulty they had in finding somebody who would answer their calls, who would help them, I don't see that really being functional.

Mr. John Fraser: Thank you very much for bringing that here today.

Ms. Ann Hoggarth: Is there any time left?

The Chair (Mr. Peter Z. Milczyn): Yes, there's a bit of time left; 30 seconds or so.

Ms. Ann Hoggarth: I'm just going to read the eligibility criteria because I think some of the things we've heard today—it seems like you could just walk in and ask to end your life.

Dr. Chantal Perrot: I cannot imagine that.

Ms. Ann Hoggarth: No. You must be 18 years and competent; have a grievous and irremediable medical condition, which means serious and incurable illness, disease or disability; an advanced state of irreversible decline in capabilities; enduring physical or psychological suffering, caused by the medical condition, that is intolerable to the person; and natural death has become reasonably foreseeable; voluntary request required; informed consent required; and eligible for publicly funded health care in Canada. You must also have initial medical opinions by a physician or nurse practitioner and a second medical opinion by an independent physician or nurse practitioner; personal request in writing or by—

The Chair (Mr. Peter Z. Milczyn): Ms. Hoggarth, that's—

Ms. Ann Hoggarth: Sorry, but—

The Chair (Mr. Peter Z. Milczyn): You went over a bit—

Ms. Ann Hoggarth: It's not as easy as it's been—

Dr. Chantal Perrot: It is not at all easy and it requires extensive assessments.

Ms. Ann Hoggarth: Yes.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you very much for bringing your point of view to committee, and notes have been taken.

A lot of the concerns you've raised—I think the government could play a good role in ensuring that eHealth finally rolls out, that you could access those records instead of waiting for a doctor's transfer, or that we have the CCACs and this effective referral system set up to help. I do think the effective referral would be beneficial, unless you've heard other stories in Alberta that it's not effective. I've yet to hear a story that Alberta people aren't getting the access they need. I don't know if you've heard that at all.

Dr. Chantal Perrot: I don't know.

Mr. Jeff Yurek: Because their system is what the government is proposing to do and we're supportive of, and we think that would take up the point of people having access.

Dr. Chantal Perrot: I do know patients who have travelled from Alberta elsewhere to have procedures done.

Mr. Jeff Yurek: Before this legislation, before the effective referral was started up?

Dr. Chantal Perrot: I don't know when the Alberta legislation came in.

Mr. Jeff Yurek: I'm trying to find someone who has said there is a problem. All I keep hearing is it's a system that works. It's a system that—

Dr. Chantal Perrot: I know people I can ask and I can find out.

Mr. Jeff Yurek: That would be great. You've got probably till next Thursday to do that and submit it. That would be fine.

The one question I had, which I thought was quite shocking, is that on the death certificate it's listed as suicide.

Dr. Chantal Perrot: That's right.

Mr. Jeff Yurek: Does this legislation fix that problem, or no?

Dr. Chantal Perrot: I'm hopeful that it will, ultimately, lead to fixing that problem, but so far, no.

Mr. Jeff Yurek: Would you think medical assistance in dying should be on the death certificate?

Dr. Chantal Perrot: Yes. I think medical assistance in dying should be the cause of death, and then the primary illness that contributed to the patient seeking MAID should also be listed there. At this point, my understanding is that medical assistance in dying is not on the death certificate at all, and when we fill out the death certificate, it's suicide.

Mr. Jeff Yurek: That's interesting. Okay, thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas.

M^{me} France Gélinas: Unfortunately, we are here in second reading to try to find common ground to move things forward—not the best place. I sort of thought that maybe we had found a place where self-referral would work, but what you are telling us is that you have experienced—you are the only one so far who has come to us who has experience. In your experience, the patient requires help; they cannot reach out on their own. Some of them basically would be denied access if there was not a health professional helping them. Did I hear you right?

Dr. Chantal Perrot: Ultimately, yes. I think your situation of a patient in a nursing home who has no family—there are lots of patients like that who have nobody they can call on. Or, if they do, they're afraid to call on their family, because this is something that they want to do, and they want to explore it on their own without necessarily involving family until later in the process.

So how do they find out about MAID? How do they find out the information, the requirements, the criteria? How do they get access to an assessor? These are functions that are hard to do. For people to find a family doctor in Ontario if they want to have a CAT scan for something, if they want to see a specialist for something, they can't just call and ask to book it. They have to go through a physician and be referred specifically for it.

My understanding is that physicians who are asked about MAID are obligated to tell the patients about the eligibility criteria and how they can access it. I think that's the minimum that should happen. But, in my experience so far, a lot of physicians have not informed themselves about Bill C-14 or the eligibility criteria and there's a lot of misinformation, unfortunately, that patients are being misinformed.

M^{me} France Gélinas: You've also hinted at health care professionals not co-operating with the information needed for the two assessors to do their work. Do you feel that this is something that we should get involved with, to make sure that there is—or is this something that will sort itself out by itself if we leave it alone?

Dr. Chantal Perrot: I think it should be part of the effective referral. For the physicians who are conscientious objectors, if they have been the patient's primary medical practitioner for any period of time, ultimately, it's from them that I would need to get the records. So when I call their office and say I'm assessing a patient for MAID and I need medical information that will corroborate the patient's history, are they going to provide it to me? Or will they see that as aiding and abetting somebody getting MAID and object conscientiously? I don't know.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Perrot. If there's something you'd like to submit in writing, you can do so until 6 p.m. next Thursday, March 30.

Dr. Chantal Perrot: Thank you.

ARCHDIOCESE OF TORONTO

The Chair (Mr. Peter Z. Milczyn): Our next witness is the Archdiocese of Toronto. Good afternoon, Your Eminence.

Cardinal Thomas Collins: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation. If you could please state your name for the official record, as you begin.

Cardinal Thomas Collins: I'm Thomas Collins, Archbishop of Toronto. Good afternoon. Thank you for this opportunity. By way of background, I serve as the spiritual leader of the Catholic Archdiocese of Toronto, which is comprised of two million Catholics and 225 parishes, with services celebrated each week in more than 35 languages.

Long before Canada was a country, the church, often under the leadership of religious sisters, created hospitals and other havens of care and comfort. To this day, in those institutions, and elsewhere as well, doctors, nurses and other health care workers continue to devote their lives to the healing vocation of medicine, motivated by their faith and by their profound personal reverence for the dignity of the human person. It is sad that I and others need to come before you today to urge you to protect these devoted healers from the punishment which they face if they refuse either to administer a lethal injection to their patients or, in effective referral, to arrange for that injection to be administered.

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We all know people who have experienced suffering throughout life, and especially as they come to the end of their life. As a society, we must offer them relief by making high-quality palliative care available to all. As a community, we seek to do all that we can to offer hope to those contemplating suicide. Unfortunately, suicide is now recognized legally as a legitimate option. It is our challenge to offer the loving accompaniment and expert mitigation of physical pain that will demonstrate to a person who is suffering in mind or body that there is another path.

Although the term “medical assistance in dying” is used currently as a harmless-sounding expression to cover over the grim reality of assisted suicide, we obviously should provide appropriate medical assistance to people who are dying. Not long ago, my sister Patricia died from pancreatic cancer, and I am grateful for the loving care and control of pain offered by the doctors and nurses at the Guelph General Hospital, who gave her medical assistance as she was dying. Death comes to us all, and we need not extend earthly life when it is ending.

We need to offer love and medical assistance to those who are dying, but that is utterly different from administering an injection which is designed to kill them. When a person is in pain, the solution is to kill the pain, not to kill the patient. Those guided by that principle need protection, so that they can act according to their conscience. This is necessary because the College of Physicians and Surgeons of Ontario has decreed that those who refuse to

perform a procedure that is against their conscience must arrange for it to be performed. That is an unjust dilemma: Either do it, or make it happen.

Every other foreign jurisdiction that has legalized assisted suicide recognizes the radical moral conflict faced by doctors and nurses. These countries and states have ensured that health care professionals have robust conscience protection. Eight other provinces in Canada provide conscience protection, yet Ontario, where it is particularly needed, refuses to do so.

In the past year, I have met with dozens of elected members of Parliament at both the federal and provincial level. In the last two months, more than 20,000 letters have been sent to members of provincial Parliament on this issue. But to me, most striking are the personal stories I have heard from countless devoted doctors and nurses who cannot in good conscience cause their patients' death. I've heard some just now, just in the last hour or so.

We must think as well of medical students, who are the future of compassionate health care. Already, voices are being raised to screen out of the medical profession those who are not willing either to administer a lethal injection or to arrange for it to be administered.

It is particularly troubling that while Bill 84 has a clause to ensure that we will protect the rights of doctors who will help to kill their patients, we do not provide any protection for those who ask not to participate in the act. Many patients want to be cared for only by physicians and nurses who they can be sure are not willing to kill. We must not abandon those patients by driving out or screening out such physicians and nurses.

I am appealing to you today to work across party lines with your colleagues, to include an amendment that will provide robust conscience protection for those who do not wish to participate in or—which is the same thing—to arrange for the death of their patients. There are many examples for you to reflect on of the conscience protection that is in place in other jurisdictions which allow assisted suicide.

Let us strive to protect doctors, nurses, and all health care workers, who serve us so faithfully, and who seek to heal, and to ease pain, but who refuse to kill. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Your Eminence.

Mr. Yurek, three minutes.

Mr. Jeff Yurek: Thank you for being here today and for giving those words. Ontario is a diverse province with different beliefs and different thoughts on rights. We even had a humanist here today who spoke out.

I think this issue of conscience protection really comes down to individual rights and beliefs, and whether there's a feeling that those individual rights and beliefs need to be trumped in order to provide a medical service. I don't know if you had any thoughts on that.

Cardinal Thomas Collins: Well, I think that each person has the right to act according to their conscience. I think that actually serves the common good. It's not just simply an individual thing.

When we have a society in which people's conscience is run over, our whole society is in deep trouble. I think that earlier, just about an hour ago, others had mentioned this: To be in a sense driving out of the profession people who are being forced or pressured, especially by the College of Physicians and Surgeons, is not going to help our whole community. It's not just a matter of an individual right or an individual thing; it's a thing that affects our whole society. I think that's a problem.

Mr. Jeff Yurek: I think it works towards adding stresses to the profession and seeing those who want to provide the care leaving their chosen profession. The way I see it, what we should be discussing as a Legislature is that an organization, the College of Physicians and Surgeons, has made a ruling on what they believe is effective referral. I think it's up to us to have that opportunity to address whether or not we want to ensure that people have the ability to have their own conscience beliefs respected and protected.

Cardinal Thomas Collins: If we don't have that, we're in very deep, deep trouble. I would say that, obviously, for the physicians who have spoken so passionately of the situation they find themselves in, the pressure they're under. But I also say that institutions have consciences too. It's called their mission.

When I think of the urban angel that I live just next to, St. Mike's Hospital, and when I think of St. Joseph's and the Providence centre, I think of the sisters who founded them. They have a conscience, and that conscience is called their mission. They don't do these things. They're there to provide a refuge and a hope, and it serves our greater community that they're there. Thank goodness for that. I think that is what we need to protect as well, as well as individuals. We all pay taxes, by the way—I believe all of us do. There's no sacred piece of money out there called, I don't know, “sterilized money” that comes from taxpayers. We're taxpayers. I think that when we pay our taxes, we should be able to support a system which reflects and respects the conscience of individuals and of institutions, which have principles.

Mr. Jeff Yurek: Do we have time?

The Chair (Mr. Peter Z. Milczyn): That's the three minutes.

Madame Gélinas.

M^{me} France Gélinas: I want to thank you so much for coming here and sharing your thoughts with us. It's not very often that we have an archbishop and a cardinal come to Queen's Park, so I certainly appreciate you. I understand that if you came here today, it's because it's something that is very important to you, to your church, and to the people who share your values and are part of the Catholic church.

There is one part of the bill that I don't know if you're comfortable talking about, but let me know. There's a part of the bill that says that we cannot ask which hospitals will be participating in MAID and which won't. It is obvious to me, and obvious through what you've said, that all of our Catholic hospitals, through their mission, are not going to participate in this. Yet would there be

any harm in letting people know that? Because it's in the bill right now that we're not going to let them know that.

Cardinal Thomas Collins: Well, I don't think I'm competent to comment on the details of that in terms of letting people know.

No hospital provides every service. All hospitals provide different things. People are being moved from place to place for all kinds of things. I think we all have experience of that. I think to require every hospital to do it obviously would not make sense. We do have some that will do this, and some will not, dependent upon their position. I think that is probably the way it'll be.

As to making it known who would do this or not, I'm not familiar with that.

M^{me} France Gélinas: And do you have any inkling as to which way we should go?

Cardinal Thomas Collins: Well, I do think that especially because of the really problematic, to put it mildly, approach of the College of Physicians and Surgeons, we do need to provide protection for individual doctors and nurses and people like that. But also I think we do need to be respectful, obviously, of people who are committed in conscience and whose conscience informs the basis of the mission which has served our community and our whole province and our individual communities so well.

There are ways of doing this. There are people—and we just heard a person who is fine with doing this, and they are there. But we should not force people or institutions to do what is against their conscience.

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M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser.

Mr. John Fraser: Thank you very much, Your Eminence, for being here today and for your presentation. We are almost finished a full day of hearings today, and we have heard about compassion and mercy and love from all the deputants, as a matter of their own conscience. So I understand what you are saying about conscience rights.

You may have been here a bit earlier, when we were discussing about how do we make pathways that will allow for practitioners of different consciences to make sure that their patients are provided the care that they need, given the Supreme Court decision and the subsequent legislation and the two rights that we have been talking about this afternoon.

I know there has been talk about a care coordination service. I don't know if you have any thoughts on that?

Cardinal Thomas Collins: I think there are obviously different opinions and different profound convictions on different sides of this issues. It depends what you mean by a care coordination service. If I may say, the devil is in the details. You have to see what it means.

I think Dr. McQueen very perfectly expressed it, that such a thing is a great idea but the key is that it be set up in a way—as it is, it's happening; it's happening all the time, I believe, in Alberta—where the individual who wishes for that, or their friends or their family or people

working for them, can do it directly without pulling into it and forcing to engage in it someone for whom this is profoundly against their very person, of who they are.

This can be done. It's not as if it's impossible. This can be done, and it is being done. In fact, we're the only place that isn't doing it. Everywhere around the world, they respect conscience, even places which are really strong on assisted suicide—which I think is very sad—but they do respect conscience.

Mr. John Fraser: Okay. We did hear earlier this afternoon about how people have arranged institutions to make sure that it works and that people get access to the host of services that they need, and doing that in a way that respected everybody's rights. It was very distressing to hear earlier today about—we don't want it where people are standing up and saying to each other, "We can't work together." The whole point is for people being able to continue to work together and provide all the care that their skills allow them to provide.

Cardinal Thomas Collins: I think it's very important for people to be able to offer those skills in a way in which they can do it serenely and fruitfully. When they're put under pressure, that "we better all do this or somebody better"—that's not fair, that's not right.

Part of the issue is what's going to be in Bill 84. I think that's what we need to look at. But also part of the issue in our province is the College of Physicians and Surgeons of Ontario, with its policy that if you don't want to do it, you make it happen. That is just unfair. It is causing misery. It's bullying. I think somebody has to stand up about this. If it's not the Legislature, then I ask, who?

Mr. John Fraser: Do I have any time?

The Chair (Mr. Peter Z. Milczyn): No, that's all our time.

Thank you, Your Eminence, for coming this afternoon. If there's something that you would like to submit in writing to us, please do so by 6 p.m. next Thursday.

Cardinal Thomas Collins: Thank you very much.

ASSEMBLY OF CATHOLIC BISHOPS OF ONTARIO

The Chair (Mr. Peter Z. Milczyn): Our next witness is the Assembly of Catholic Bishops of Ontario. Good afternoon, Bishop. You have six minutes for your presentation, and if you could please state your name for the official record as you begin.

Bishop Ronald Fabbro: My name is Ronald Fabbro, and I've asked Larry Worthen if he would assist me in case there are any technical questions that he could help me with.

I want to thank you for this opportunity to speak to you about Bill 84. I am the Bishop of London and I'm also the president of the Assembly of Catholic Bishops of Ontario. Our assembly has 18 dioceses from across Ontario, and we are the spiritual leaders of about four million Catholics: Latin Rite and Eastern Rite.

I'd like to begin by speaking of my own experience in my dioceses, which include cities like London, Windsor, Chatham, Sarnia and St. Thomas. The last few weeks, in our different churches, we've invited different doctors to speak at our Sunday masses. Different doctors have stood up and spoken of the effective referral that their College of Physicians and Surgeons is requiring of them and of how it would be against their deeply held conscience beliefs. These doctors have said that they would have to stop practising medicine in Ontario if they were forced to do this.

The reaction has been really incredible. In London, we had responses from our people—2,000 letters, I heard, were written to their MPPs just in the last three weeks. For me, this is a deeply emotional response that we've received in great numbers from our people. Our people, obviously, have a respect for their doctors whether their doctor is Catholic or non-Catholic, whether they have faith or no faith. Doctors have a desire to serve those in need of healing, whoever they may be—the care and the compassion that our doctors have for those who are suffering, particularly the vulnerable. Many of our doctors are motivated by deeply held convictions and by their own religious beliefs. It was obvious in the last few weeks that our people expect their doctors are persons of conscience who will act according to their conscience and do what is right for them.

In coming here today, I have a grave concern for the plight of doctors and other health care workers who are motivated by conscience and by their religious beliefs. For many of them, it would go against their consciences if they were required to provide an effective referral. This would be an unjust burden on them. Forcing someone to go against his or her conscience is to force them to go against the very core of their person, force them to go against their very self.

According to our Catholic teaching, providing an effective referral would be immoral because it is co-operating in the act of euthanasia or physician-assisted suicide. These doctors who are forced to go against their conscience would no longer enjoy freedom of conscience or freedom of religion in the profession they have dedicated their lives to. This is true not only of our Catholic teaching; it is true of other faiths—Christian denominations or those of the Jewish faith or Muslim faith. They're speaking out. Leaders of their faith communities are speaking out with us on this issue.

I appeal to you today, members of the committee, to find a just way forward that balances the rights involved here: the legal right of a patient to physician-assisted suicide and the rights of health care providers to freedom of conscience and freedom of religion. We've heard—I just heard in the last hour or so—the third-party agency is an option that is available in other provinces, like Alberta, which respects the conscience of health care workers.

It is alarming to hear good doctors say that they would have to leave the practice of medicine in Ontario if they were forced to act against their conscience. It's unacceptable to have these doctors disciplined or risk losing their

professional standing for conducting their work according to their most deeply held ethical or religious convictions. This is why I think our people, the people in the pew, have reacted so strongly, objecting to Bill 84.

We strongly encourage you to include in Bill 84 adequate protection for freedom of conscience and freedom of religion. It's essential. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Bishop. We'll begin with Madame Gélinas.

M^{me} France Gélinas: Thank you so much, Bishop Fabbro, for coming here this afternoon and sharing your thoughts with us.

My first question is—you don't have to answer any question that you don't feel comfortable with. Have any of your parishioners come to you to say that they would be reluctant to go to a hospital or a hospice where MAID was available or, to flip it on its head, that they would like to know that, in such a hospital, MAID was not available and they would prefer to go there? Have any of those conversations come to you through your parishioners or others?

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Bishop Ronald Fabbro: I think what has come to me is how important it would be for our people to have confidence in their doctors or nurses and that they would be genuinely concerned about their health. I think that would be the primary concern that I have heard.

I think our people, because of our Catholic hospitals and other faith-based hospitals, would have a sense that the values that they have would be respected in a faith-based institution as well.

M^{me} France Gélinas: Okay. My other question is that right now, everybody focuses on active referral, because this is the position of CPSO. But we've also heard that, even if the patient self-refers to a physician or a nurse practitioner who provides MAID, they will still need to come back to their family physician, who may have religious or other conscientious opposition, to provide information, provide proof of medical tests and that kind. Is this also an issue for your church?

Bishop Ronald Fabbro: We would see the providing of information, even in our hospitals—I mean, it's readily available. That information could be provided to persons. The question that would be—if a doctor or health care provider has to go against their conscience, that would be a separate thing. But I think the providing of information would be possible in our health care institutions.

Mr. Larry Worthen: Yes, the answer to that, Madame Gélinas, according to my understanding, is that the chart, the information of the patient for their treatment, is the property of the patient. Our social teaching would say that, if the patient requests their chart, they can, of course, have their chart and then that can be transported to the doctor who's doing the assessment.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for your presentation. It's not easy being

the last presentation of the day. We might look like we're kind of glazed over a little bit.

But I just want to reflect back a little bit on the day. As I said earlier, everybody we heard from today was acting out of their conscience, be it from the side of the protection of conscience rights or access. For every person who came here today, that's a central belief to them. I think we have to respect all of those. I really believe that.

I believe that physicians, all the ones I've talked to—most of them; not all of them, but the vast majority of them—want to continue to care for their patient. How do we create a way that balances those two rights, in your opinion? You said that when you were speaking. How do we actually create that pathway? I've asked this question of a number of people, so my colleagues are probably tired of it. How do we make sure that people can follow along that pathway so they can provide that care?

Bishop Ronald Fabbro: Right now, we have one of the colleges, the College of Physicians and Surgeons of Ontario, indicating that what they consider reasonable would be to make it a direct referral. If a doctor is not, in conscience, able to commit the act of assisted suicide, a direct referral has to be made. To me, what I've heard from doctors is that that would go against their conscience.

I think the law needs to strike a balance between legal rights here and fundamental rights that the Charter of Rights and Freedoms of our country, that we stand up for, says are absolutely essential for us in a free democracy. I think that has to be enshrined in Bill 84.

Mr. John Fraser: Okay. Maybe I'll rephrase my question. The question was more, how do we find that pathway forward that I described?

Bishop Ronald Fabbro: Larry here can get into more of the details.

Mr. Larry Worthen: This morning, when I presented, I gave you a package which looks like this. On the second page of the package, we've outlined exactly how this system could work.

We know that there are concerns about patients falling between the cracks, but we've looked at four different settings where patients could find themselves and we've actually developed a care path to show how those patients could access medical aid in dying using a care coordination service. If you've gotten to the doctor's office, then you or a caregiver or someone in your family should be able to make the connection by calling the 1-800 number. If you're so sick that you can't do that, then the doctor could meet you at a hospital. If the person is in home care, then either through their CCAC care coordinator, through another caregiver or through a family member, they could contact the care coordination services. If someone's in a facility, then we already had the example in Ottawa described of how things are working there. And if you're in a facility that does not allow MAID on the premises, those facilities have committed to a complete transfer of care.

So if you look at our care path, which we've outlined here, we've demonstrated how there's a way through for every type of concern. We believe that if we were given an opportunity to dialogue on this, we would be able—if you could raise for us what other situations people might be in where they couldn't access this, we could come up with a plan to do that. Our point is there's no need for the requirement of an effective referral.

The Chair (Mr. Peter Z. Milczyn): Thank you. Mr. Yurek.

Mr. Jeff Yurek: Thank you for being here today and for being the last deputant. It's been a long day.

I know the government is asking their questions of how to proceed forward, but we've had a year to be looking at it. I'm sure they're further along than—they understand what your position is. I just hope they can expedite the creation of the referral system and at the same time ensure there's the balance of protection of conscience rights.

You made a great point: Doctors are people of conscience. To go against their conscience beliefs and their integrity injures the doctor—not only to be an active, happy participant in the medical system, but personally and spiritually, they're also affected. Any comments on that?

Bishop Ronald Fabbro: The doctor is certainly affected because it goes against their deepest convictions. If patients were in a society in which they felt that they would go to a doctor and their doctor felt coerced to go against their own conscience—we can separate this issue out, but patients depend on their doctor to be a man or a woman of conscience, and that they're going to deal with them in a way that truly cares for them. If that was not true, if you suspected that your physician was somehow not giving you what they thought was best for you because they had to go against their conscience, I think that affects all of us in terms of going to our physicians, and so it affects our society. We're living in a society where people are not allowed to follow their own profession because they're forced to go against their conscience.

So I think it affects the individual health care provider, their patients and the society in which we live.

Mr. Jeff Yurek: I agree.

Your outreach worked well. I received a stack of signed papers from Holy Angels and St. Anne's this morning, actually. I'm going through the list now.

Please keep advocating for change.

Bishop Ronald Fabbro: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Bishop, for coming today. If there's something further you would like to submit in writing, you can do so until 6 p.m. next Thursday.

It being 6 o'clock, the committee stands adjourned until 9 a.m. on Thursday, March 30.

The committee adjourned at 1800.

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